

World Relief Malawi
***Tube Poka* Child Survival Project**

Detailed Implementation Plan (DIP)
Chitipa District, Northern Malawi

Program Dates: October 1, 2005 to September 30, 2009

Cooperative Agreement No. GHS-A-00-05-00032-00



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LIST OF ACRONYMS

ANC	Antenatal Care
ARI	Acute Respiratory Infection
ARV	Antiretroviral
BCC	Behavior Change Communication
BF	Breastfeeding
CBDA	Community Based Distribution Agents
CBO	Community-based Organization
CCAP	Church of Central Africa Presbyterian
C-HIS	Community Health Information System
CHAM	Christian Health Association of Malawi
CDD	Control of Diarrheal Disease
CG	Care Groups
CHIS	Community Health Information System
C-IMCI	Community Integrated Management of Childhood Illness
CS	Child Survival
CSP	Child Survival Program
DEHO	District Environmental Health Officer
DH	District Hospitals
DHMT	District Health Management Team
DHO	District Health Officer
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DRF	Drug Revolving Fund
EBF	Exclusive Breastfeeding
EPI	Expanded Program for Immunization
FGD	Focus Group Discussion
FP	Family Planning
GMC	Growth Monitoring and Counseling
HC	Health Center
HES	Health Education Supervisor
HF	Health Facility
HFA	Health Facility Assessment
HIS	Health Information System
HP	Health Post
HQ	Headquarters
HSA	Health Surveillance Assistant
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent and Presumptive Treatment
IR	Intermediate Result
ITN	Insecticide Treated Net
KPC	Knowledge, Practices, and Coverage
LRA	Local Rapid Assessment
M&E	Monitoring and Evaluation

MGCWCS	Ministry of Gender, Child Welfare and Community Services
MN	Malnutrition
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NAC	National AIDS Commission
NMCP	National Malaria Control Program
ORT	Oral Rehydration Therapy
OVC	Orphans and Vulnerable Children
PCM	Pneumonia Case Management
PHC	Primary Health Care
PLW(H)A	People Living With (HIV)AIDS
PM	Project Manager
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
PVO	Private Voluntary Organization
RBM	Roll Back Malaria
TBA	Traditional Birth Attendant
TPCSP	<i>Tube Poka</i> Child Survival Program
TT	Tetanus Toxoid
SHSA	Senior Health Surveillance Assistant
SOL	Synod of Livingstonia
SP	Sulfadoxine-Pyrimethamine
SWA	Social Welfare Assistant
U5	under five years-old
VAC	Vitamin A Capsule
VCT	Voluntary Counseling and Testing for HIV/AIDS
VHC	Village Health Committee
WR	World Relief
WRA	Women of Reproductive Age

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A. Executive Summary

World Relief Malawi *Tube Poka* Child Survival Program

Program location and dates: Chitipa District, Northern Malawi, 1 October 2005 to 30 September 2009

Partners: Chitipa District Ministry of Health (MOH) and the Church of Central Africa Presbyterian (CCAP), Synod of Livingstonia (SOL)

Beneficiaries: 40,203 children under five (9413 children <12 months, 8335 children 12-23 months, and 22,455 children 24-59 months); 32,023 women ages 15-49 in a total population of 174,786

Funding: US\$2,022,087 [US\$1,500,000 USAID, US\$522,034 World Relief (WR) Match]

Category: Standard

USAID Mission contact: Catherine Chiphazi, PHN Officer

Proposal Authors: Victor Kabaghe, Richard Thindwa, Moses Chavula, Rachel Hower, Olubukola Ojuola, Melanie Morrow

WR Contact: Rachel Hower, Maternal and Child Health Specialist, rhower@wr.org; (443) 451 1944

Problem Statement: Malawi ranks 165/177 in the human development index with some of the worst health indicators in the world, including a life expectancy of 42 years. Infant and under five (U5) mortality rates remain high (76/1000 live births, 133/1000 live births) and maternal mortality has remained persistently high over the past decade, at 985 deaths per 100,000 live births^I. Eighty four percent of the 12.1 million live in rural areas with agriculture as the main income source for the majority of the population. Poverty is widespread with nearly 65% of the population living below the poverty line. Chitipa district, the northernmost district in Malawi, is marginalized based on levels of poverty, food deficiency and lack of access to services. An estimated 174,786^{II} people live within 475 villages that are scattered throughout the mountainous terrain of Chitipa, including 40,201 women of reproductive age and 32,025 children U5 years (9413 children <12 months, 8335 children 12-23 months, and 14,277 children 24-59 months), and an estimated 16,472^{III} orphaned children. Distances to health facilities in Chitipa average 8 kilometers; those in the extreme north areas of Musumbe and Nthalire often travel further, some up to 40 hours to the central district hospital^{IV}.

National attempts to decentralize the health system have been hindered by a continued emphasis on curative services and insufficient resources. According to Demographic Health Survey (DHS) data and other local assessments, the primary causes of U5 mortality and morbidity in northern Malawi continue to be malaria, pneumonia, diarrhea disease and malnutrition. Current household prevention and care seeking efforts are inadequate, with just

^I Preliminary DHS Report, 2004

^{II} Tube Poka Project Census, Chitipa, Malawi 2006

^{III} Tube Poka Project Census, Chitipa, Malawi 2006

^{IV} WR focus group interview results, 2003

23% and 32% insecticide treated net (ITN) use^V among women and children under five, only 18% of under fives treated at a health facility for reported rapid, difficult breathing/suspected pneumonia, 41% of children suffering from diarrhea drinking less fluids than usual^{VI}, and 70% of under five children chronically malnourished^{VII}. Malaria is endemic, contributing to 40% of the disease burden of under-fives^{VIII} and remains the primary cause of fever incidence (69%)^{IX}. Lack of knowledge, access and financial resources prevent utilization of health services. Efforts to fully extend Integrated Management of Childhood Illness (IMCI) at the community and household level have not been fully institutionalized, and community mobilization is needed to ensure timely and appropriate care. HIV/AIDS sero-prevalence among adults is 15%, the eighth highest rate worldwide,^X with a rapidly growing orphan community of 500,000 children who make additional demands in the poorest households. One third of all poor households are headed by women. Like most of Southern Africa, Malawi experienced acute food shortages in 2002 that further worsened the health status. Health indicators illustrated above necessitate the following interventions.

Intervention mix and Level of effort: Malaria prevention and case management 30%, Nutrition, including Exclusive Breast Feeding (EBF), micronutrients and the *Hearth* Program 20%, Control of Diarrheal Diseases (CDD) 15%, Pneumonia Case Management (PCM) 10%, Immunization 20%, and HIV/AIDS prevention 5%.

Program Approach:

WR's Child Survival Program (CSP) in Chitipa district will 1) strengthen the capacity of the health district to implement Child Survival and Health interventions by improving the quality and coverage of C-IMCI services through training, supervision and by establishing an effective health information system, 2) develop sustainable community based mechanisms to improve preventive and care seeking practices for childhood illnesses at the household and community level.

The CSP aims to reduce disease burden and morbidity among target beneficiaries using the Care Group (CG) model, which has demonstrated sustainable impact for child survival and reduced mortality trends in Mozambique (64%)^{XI}.

The CG strategy is based on an extensive network of volunteers (3060 for the project area) trained to provide universal coverage of services to all households. The network of Care Groups is organized using a 'block structure'; every volunteer is responsible for an average of 10 households, promoting behavior change communication (BCC) for key household practices and prompt care seeking. CG volunteers will be mentored by local project staff and trained by health personnel skilled in C-IMCI using a cascade approach and standard protocols endorsed by the MOH. The CSP will integrate the CG networks within existing institutions, including Village Health Committees (VHC), pastors, traditional healers, and

^V Preliminary DHS Malawi 2004

^{VI} UNICEF, 2002

^{VII} UNICEF, 2002

^{VIII} Vector Biology and Control Project, Tropical Medicine Parasitol.1194 March;45(1):57-60

^{IX} Vector Biology and Control Project, Tropical Medicine Parasitol.1194 March;45(1):57-60

^X UNAIDS, 2003

^{XI} WR Mozambique Final Evaluation Findings Report, Taylor, C. 2003

drugs sellers, and the health district, creating a sustainable support structure for the volunteers and further building capacity of communities and the health system.

B. CSHGP Data Form

Child Survival and Health Grants Program Project Summary

Jun-28-2006

World Relief Corporation (Malawi)

General Project Information:

Cooperative Agreement Number: GHS-A-00-05-00032
 Project Grant Cycle: 21
 Project Dates: (9/30/2005 - 9/30/2009)
 Project Type: Standard

WRC Headquarters Technical Backstop: Olubukola Ojuola
 Field Program Manager: Victor Kabaghe
 Midterm Evaluator:
 Final Evaluator:
 USAID Mission Contact:

Field Program Manager Information:

Name: Victor Kabaghe
 Address:
 Phone: (265) 8-505-589
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 E-mail: vkabaghe@wr.org

Alternate Field Contact:

Name: Richard Thindwa
 Address:
 Phone: (265) 8-319-400
 E-mail: rthindwa@wr.org

Funding Information:

USAID Funding:(US \$): \$1,500,000 PVO match:(US \$) \$522,034

Project Information:

Description:

Program Goals:

- 1) Strengthen the capacity of the health district to implement Child Survival and Health interventions by improving the quality and coverage of C-IMCI services
- 2) Develop sustainable community based mechanisms to improve preventive and care seeking practices for childhood illnesses at the household and community level

Interventions:

- Maternal prevention and care management
- Nutrition including exclusive breast-feeding and micronutrients
- Control of diarrheal diseases
- Pneumonia case management
- HIV/AIDS prevention
- Child immunization

Strategies:

Community Integrated Management of Childhood Illnesses (C-IMCI) will be implemented using the Care Group strategy; other strategies will include PD-Health, HIV/AIDS prevention adopting World Relief's Mobilizing for Life strategy.

Location:

Chitipa District, Northern Malawi

Project Partner	Partner Type	Subgrant Amount
Chitipa District Ministry of Health	Collaborating Partner	
Church of Central Africa Presbyterian (CCAP), Sowed of Living Waters (SOL)	Collaborating Partner	

General Strategies Planned:

Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
 Health Facility Assessment
 Organizational Capacity Assessment with Local Partners
 Organizational Capacity Assessment for your own PVO
 Participatory Rapid Appraisal
 Participatory Learning in Action
 Community-based Monitoring Techniques
 Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
 Peer Communication
 Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) Field Office HQ CS Project Team	(None Selected)	Pharmacists Traditional Healers	Dist. Health System Health Facility Staff	Health CBOs CHWs

Interventions/Program Components:

Immunizations (20 %)

- IMCI Integration
- CHW Training
- HF Training
- Catch & Vaccinate
- Vitamin A
- Surveillance
- Mobilization

Nutrition (20 %)

- IMCI Integration
- CHW Training
- HF Training
- Comp. Feed. from 6 mos.
- Handh.
- Diet. BF up to 24 mos.
- Growth Monitoring

Pneumonia Case Management (10 %)

- IMCI Integration
- CHW Training
- HF Training
- Prompt Case Mgmt.
- Case Mgmt. Counseling
- Recognition of Permanent Danger Signs

Control of Diarrheal Diseases (15 %)

- IMCI Integration
- CHW Training
- HF Training
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Case Seeking
- Case Mgmt. Counseling

Malaria (30 %)

- IMCI Integration
- CHW Training
- HF Training
- Linkage to Malaria CM
- Access to providers and drugs
- Adherence, Prevention Treatment
- ITN Bednets
- Case Seeking, Referral, Compliance
- IPT

HIV/AIDS (5 %)

- CHW Training
- Behavior Change Strategy

Target Beneficiaries:

Infants < 12 months:	4,743
Children 12-23 months:	5,205
Children 24-59 months:	17,745
Children 60-59 months:	11,237
Children 6-59 Months:	12,835
Women 15-49 years:	40,781
Population of Target Area:	174,786

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (<2 SD from the median weight-for-age, according to the WHO 2007 reference population)	105	361	29.36%	7.4
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	110	319	34.50%	8.6
Percentage of children age 0-23 months whose births were attended by skilled health personnel	201	364	55.22%	9.2
Percentage of mothers of children age 0-23 months who reported at least five return record inspections before the birth of their youngest child	113	364	64.00%	9.6
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	20	50	40.00%	7.2
Percentage of infants age 6-6 months receiving breastmilk and complementary foods	75	196	38.27%	11.2
Percentage of children age 12-23 months who are fully vaccinated against the five vaccine-preventable diseases before the 12th birthday	235	346	68.21%	10.8
Percentage of children age 12-23 months who received a measles vaccine	191	346	55.20%	9.4
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in urban areas only)	66	161	41.00%	12.5
Percentage of mothers who know at least two signs of childhood illness that indicate a need for treatment	114	319	71.10%	10.3
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	17	311	3.9%	3.1
Percentage of mothers of children age 0-23 months who use at least two known ways of reducing the risk of HIV infection	143	260	55.00%	9.8

Percentage of mothers of children age 0-15 months who wash their hands with soap and water before food preparation, before feeding children, after defecation, and after attending to a child who has diarrhea	115	319	28.94%	3.1
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Comments for Rapid Catch Indicators

C. Description of DIP Preparation Process

Strategic meetings were held on individual and group bases over two weeks from January 20 to February 3rd, 2006, to discuss the main components of the DIP. Key individuals were interviewed, including the Chitipa District Commissioner (DC), the Chitipa District Health Officer (DHO), village headmen, as well as several community-based groups, including Village Health Committees (VHC). A DIP workshop was held in Chitipa in February that brought together major stakeholders to seek their input during the DIP stage of planning for the program, and to ensure buy-in for the program. Participants included project staff, Chitipa District Assembly and MOH staff, clergy, and community development officers. The meeting was facilitated by the CSP Program Director, Deputy Director and Child Survival Specialist. Names and affiliations of participants are listed below in Table 1.

Table 1: DIP Workshop Participants.

<u>Participant</u>	<u>Title</u>	<u>Affiliation</u>
Jusi Nyirenda	MCH Coordinator	Chitipa District Hospital
Moses Chavula	DEHO	Chitipa District Hospital
Derrick Luweshu	District AIDS Coordinator	Chitipa District Assembly
Franklin Y. Msiska	Ag. Dir. of Planning & Devt.	Chitipa District Assembly
Mufwano Msiska	District Comm. Dev't Officer	Community Development Dept.
Rev. Langster Bakazunga	Pastor	Evangelical Lutheran Church
Fr. J.B. Moyo	Rev'd. Father	St. Michael's Catholic Church
Rev. Brown S. Chilongo	Pastor	Assemblies of God Church
Rodwell Chunga	District Soc. Welfare Officer	Social Welfare Department
Rev. M.H.K. Mwangonde	Pastor	CCAP, Chitipa
Shepherd H.E. Nyondo	Pastor	New Apostolic Church
Victor Kabaghe	Program Director	WRM-CSP, Chitipa
Olubukola Ojuola	CSP Specialist	WR HQ, Baltimore
Richard Thindwa	Deputy Director	WRM-CSP, Chitipa
Rachel Mlakata	Secretary	WRM-CSP, Chitipa
Thomas Nkhonjera	Health Education Supervisor	WRM-CSP, Chitipa
Martha Jill Mtambo	Health Education Supervisor	WRM-CSP, Chitipa
John Mbene	Health Education Supervisor	WRM-CSP, Chitipa
Bosman Banda	Health Education Supervisor	WRM-CSP, Chitipa
Foreword Chilanga	Health Education Supervisor	WRM-CSP, Chitipa
Paul Ng'ambi	Health Education Supervisor	WRM-CSP, Chitipa
Richard Thindwa	Deputy Director	WRM-CSP, Chitipa
Victor Kabaghe	Program Director	WRM-CSP, Chitipa
Mbasa Msiska	Accounts Assistant	WRM-CSP, Mzuzu Office
Joseph Chavula	Logistics/Admin. Assistant	WRM-CSP, Mzuzu Office
Rachel Msiska	Secretary	WRM-CSP, Chitipa
German Phikani	Office Assistant	WRM-CSP, Chitipa
Isaac Munthali	Driver	WRM-CSP, Chitipa
Andrew Kasache Banda	Driver	WRM-CSP, Chitipa
Nelson Mwandwanga	Driver	WRM-CSP, Chitipa

After initial one-on-one discussions, major stakeholders were invited to a workshop chaired by the District Commissioner's office, for information and updates on program activities and to discuss program goals and implementation, including sustainability strategies. During the workshop, stakeholders received an update on the purpose of the project, the scope of CSP activities, the program approach, as well as highlights of baseline assessments. Stakeholders' input concerning specific aspects of the program, particularly sustainability strategies, were discussed extensively. The meeting was chaired by the DC's representative. A lively and rich discussion resulted in specific observations and recommendations, highlighted below:

1. Findings of baseline assessments were illuminating and surprising to some of the participants, especially those working with existing health programs. Participants were particularly surprised by the low level of health knowledge exhibited by the Chitipa population. The MOH and Social Welfare Department staff who had participated in these assessments corroborated the validity of information presented, and expressed their amazement at the responses received from some of the people interviewed during the surveys and focus group discussions.
2. The concepts of true volunteerism versus incentive-dependent volunteerism were discussed at length. The distinction between these two was made clear, and the group came to the conclusion that incentive-based volunteerism limits the ability of programs to have a lasting impact in the community. There was remarkable support for World Relief's approach of true volunteerism.
3. Strategies to ensure sustained program impact were also discussed, including the formation of a multi-agency advisory committee to promote continued active participation of all stakeholders. The composition of these committees will be further discussed as the CSP director and his deputy follow up with the participants.

CSP program scope, approach and implementation strategies were also discussed at various individual meetings, including strategic meetings with Catherine Chiphazi, USAID Health and Nutrition Officer, Dr Doreen Ali, National Malaria Control Program Deputy Director in Lilongwe, Dr Lucy, Project Officer, IMCI/Early Childhood Development, UNICEF Lilongwe; the Chitipa District Health Officer, and the Chitipa District Statistician, among others.

Meetings were also held with community health worker groups, including community-based distribution agents (CBDAs) for family planning, Health Surveillance Assistants (HSAs), Social Welfare Assistants (SWAs) and VSO volunteers (attached to the Social Welfare Department).

Country level meetings were held with World Relief's Malawi Country Director and Finance Manager to discuss mechanisms for ensuring adequate financial and logistical support for the program, considering Chitipa's remote location from the country office and government of Malawi base in Lilongwe. Mechanisms for integrating CSP activities with other WR health programs, especially HIV/AIDS, were examined, and follow up actions were identified.

The Chitipa District MOH District Health Environmental Officer (DEHO), Mr. Moses Chavula, was actively involved in planning and facilitating all meetings held at district and

national levels, and was involved in reviewing and editing major sections of the DIP. In addition, he provided much needed insight into current MOH operations and future plans for health programs at the district level.

Community stakeholders' meetings, including key informant interviews and focus group discussions were held with community leaders, village headmen, women, men and youth groups to obtain information about cultural beliefs, attitudes, and practices concerning common illnesses and diseases in the community, focusing on women aged 15-49 and children under-five. Joint meetings were held with village headmen and church leaders both to introduce the program and promote buy-in and ownership of the program among their ranks.

Program implementation strategies have been modified to reflect input from meetings with stakeholders in addition to results from formative research in the community.

Project start-up activities, including baseline studies

The initial KPC survey was conducted by project staff in April 2005, with certain indicators evaluated during the first LRA (April 2006) to comply with Rapid Catch indicator requirements. Focus Group Discussion summaries are presented in Section E2: Summary of Baseline and Other Assessments. Field staff members have been recruited and staff orientation and training are well underway. The Project Deputy Director is based in Chitipa, providing direct implementation guidance to project supervisors and promoters. Volunteers have been selected, Care Groups formed and initial training for malaria and pneumonia interventions have been completed. Care Group volunteers have begun conducting home visits and teaching health messages to their assigned households, starting with malaria and pneumonia interventions. The first LRA evaluated the knowledge of mothers and care givers concerning malaria prevention and care seeking practices. These results are currently being analyzed by project staff.

The CSP director and deputy made follow-up visits to the SOL health team in Mzuzu and to the MOH and community partners in Chitipa, while the WR HQ team maintained regular contact by email and phone after returning to the US. Final DIP writing took place at WR HQ in Baltimore, with regular review and input by the field.

The *Tube Poka* DIP will serve as the guide for program implementation and the main reference document at midterm and final evaluations.

D. Revisions (from original application)

Population: The total population in the project area is about 36,000 higher than estimated in the proposal. Due to this increase and wide population dispersion across a mountainous area, the numbers of volunteers and CGs have been increased to 3060 (from 2750) and 306 (from 225) respectively. Volunteers who have long distances to cover to reach their neighbors are

responsible to visit fewer than 10 households each. The result is that more volunteers (and therefore CGs) are needed to achieve full coverage of the target population. Each promoter, therefore, has a higher number of Care Groups to train and support, but mechanisms to ensure effective supervision of promoters are in place. Budget implications include larger quantities of training materials and incentives for volunteers and higher costs related to promoter travel.

Interventions: At the time the proposal was written, childhood immunization coverage rate was near universal, but the recent KPC (April 2005) survey revealed a measles coverage rate of only 55.4% by 9 months of age. Marked decline in immunization coverage rates have been reported nationwide, warranting a measles mop-up campaign in December 2005. Reasons for the low coverage rates identified by the Chitipa District MCH Coordinator and EPI team include cold chain breakdown and logistics problems such as shortages of paraffin and vehicles for outreach, as well as poor supervision and record keeping. After UNICEF achieved near universal coverage in 2003, it reduced the intensity of logistical support (contributing to the current declining rates), but they continue to provide capacity building for MOH staff and other support to the district. Also, focus group discussion (FGD) findings revealed that many mothers do not know the purpose of tetanus toxoid (TT) vaccine in pregnancy or the reproductive years, which may explain the sub-optimal TT coverage rates (64%) reported for Chitipa.

These survey findings have necessitated the inclusion of childhood immunization in the intervention package for the current program, to educate mothers and care givers on the importance of timely vaccinations and mobilize them to access available services, as well as to strengthen MOH capacity to deliver immunization services in a timely fashion. However, because of the challenges associated with implementing six interventions (including immunization) over a four year period, the project is streamlining some of its other interventions, most notably reducing the level of effort for HIV/AIDS to 5%. HIV/AIDS prevention activities of other actors have increased since the time of the proposal. Separately, WR's Malawi country health team is exploring funding opportunities from the National AIDS Commission (NAC) for HIV/AIDS programming in Chitipa District.

Office location: The original plan to have an office in Karonga in addition to the Chitipa office has changed. Instead, WR's office in Mzuzu has been maintained, both because it's closer to the capital city, Lilongwe (which allows for easier access to national and international partners and the WR country office), and because WR's CSP partners (CCAP and MOH) have regional administrative offices in Mzuzu. The WR office in Mzuzu is located within CCAP premises, facilitating partner communication. In addition, Mzuzu has better communication facilities than Karonga, particularly with regard to internet. To ensure that project implementation receives adequate attention and supervision, the CSP Deputy Director resides and works in Chitipa, and the Program Director spends at least 50% of his time in Chitipa to provide technical and management support, splitting the rest of his time between Mzuzu and Lilongwe. The team is working to ensure that telephone line and internet connectivity are available at the Chitipa office as soon as possible.

Operations Research: World Relief will collaborate with UNICEF and partners addressing the needs of OVCs within Chitipa District but will no longer undertake independent activities, including OR, related to OVCs. Since proposal submission, UNICEF has begun working with orphans through the Ministry of Gender and Social Welfare, using community based organizations (CBOs) and community-based child care centers (CBCCs) to provide services similar to the main components of the proposed OR. Furthermore, reservations were expressed in proposal review that the OR looked poised to compete with rather than enhance program implementation. Removing the OR component of the HIV/AIDS intervention is also consistent with reducing overall level of effort in this intervention, shifting resources to respond to newly revealed needs in immunization.

Equipment procurement: Project computers were not purchased, but were donated by a WR partner, Westwood Church, in Minnesota.

Sustainability indicators: Sustainability indicators have been developed and incorporated into the list of program indicators to help monitor progress towards achieving sustainable impact at the end of the program. Specifically, the following sustainability indicators have been identified, and will be measured at regular intervals:

- Percent of pastors/traditional healers, and HSAs who receive training in C-IMCI
- Percent of CG supervised by HSAs
- Percent of CG with at least 70% attendance
- Percent of VHCs that met in the preceding 2months

Response to Proposal Review Comments

(Refer to Annex A for the summary score sheet and full external reviewer comments.)

PVO Applicant

Comment: *Based on WR's experience and the successful results of its Care Group approach, WR should be working at a more national level demonstrating that this approach can be implemented at scale nationally and regionally, rather than continuing to implement at small scale district levels.*

Response: World Relief agrees. Unfortunately, Ministries of Health are rarely positioned to move as quickly as smaller, more agile NGOs might hope. However, it should be noted that World Relief is deliberately working in partnership with the Ministry of Health at the district and local level of an entire district. Working hand in hand with the government system of Health Surveillance Assistants, World Relief and the District will demonstrate a model of what could be scaled up to a regional or national level in the future.

On a national level, the Project Director has been in dialogue with National Malaria Control Program Deputy Director regarding possible adaptations of the CG approach that could be used in promoting malaria prevention at community level, in line with NMCP strategic plan. There are also ongoing discussions with NAC to explore possibilities of using the CG system to monitor ARV adherence among HIV/AIDS patients in areas where the CG system is already established. WHO is exploring the possibility of using the CG model for delivering

DOTS for TB care in Malawi, and an NGO consortium recently visited WR's former CSP site to learn how to adapt the CG system to deliver PD/Hearth services in communities with high malnutrition rates. The WR Malawi team is in discussion with these groups to help facilitate the successful care group implementation. Regionally, the CG approach is being implemented by Salvation Army Zambia in its current CSP, providing an opportunity for cross learning and the possibility of sharing technical support from the Malawi CSP.

Program Strategy and Interventions

Comment: *Include strategies that strengthen health services to ensure consistency in messages and practices between services and the community. This discussion should indicate how this will be done, with corresponding activities reflected in the training plan and budget. A more complete training plan would be useful...how many people from each cadre will be trained and in what.*

Response: Before introducing each intervention in the community, content and key messages will be shared with health facility staff both as a refresher and to apprise them of what messages are being stressed in the community.

Comment: *Clarify how program is proposing to assure coverage of the full district, especially those areas that are less active. It would be helpful to include more explanation on how the role of the HSAs will be maximized and supported.*

Response: The Care Group model uses a "saturation coverage" design which ensures that every household with a child under age five or a woman of child-bearing age receives a volunteer visit at least twice a month. Each volunteer is responsible for visiting and teaching health lessons to mothers and other important health decision-makers in the ten households (or less, if there is great distance between HHs) closest to him/her. Refer to Section E2. Program Strategy for a detailed description of HSA involvement and relationship with CGs.

Comment: *Knowing that volunteer motivation has been a problem in Malawi since the fall of Banda, it would be helpful to include further discussion on the motivation and maintenance of the CG volunteers. There should be per diem costs for training in the budget, unless it is under volunteer training supplies.*

Response: Volunteer recruitment, motivation, training and retraining addressed in the program description. Because per diems are difficult to sustain, especially for over 3000 volunteers, the project will not become dependent on them. The previous CSP (2000-2004) was successfully implemented without the use of per diems for volunteer training. Volunteers are trained to provide service without monetary compensation, looking at the long-term goal of transforming their communities through behavior change communication. However the project will provide small volunteer incentives (in the form a t-shirt, skirt, etc.) on an annual basis to show appreciation for their efforts.

Comment: *Since previous studies show that distance and cost are major factors for non-use of modern health facilities, include a discussion of how referral will work if there is no transportation or other support.*

Response: To ease transport problems in emergencies, ambulances have been made available for patient transfer from peripheral centers to the district hospital. All but one of the Health Centers in Chitipa has an ambulance. Ambulance availability does not overcome all of the barriers associated with referral, but it does ease the problem significantly. Concerning the issue of financial barriers, services are provided free of cost at government facilities, although patients face other non-monetary costs (time spent not working, etc.). In addition, the project will work with the MOH to strengthen referral mechanisms. Refer to the program description section for more detailed information.

Comment: *WR's link with the CORE Group and their recognized lead with CSP PVOs in Malawi could be enhanced. This is an opportunity for an expanded effort to become a more active leader in the country, potentially setting up an exchange program that allows the different in-country PVOs set up site visits to see the different models, with a particular focus on the WR CG model.*

Response: Site visits from other NGOs are already occurring. WR's MCH technical unit will advise the Malawi CSP when opportunities for collaboration and mutual information/model exchange become available through CORE.

Comment: *The CDD intervention should include the promotion of zinc supplements with the 'new' ORS in the treatment of diarrhea. It should recognize the importance of integrating activities around water and sanitation and increasing awareness in the community about 'point of use' disinfection.*

Response: The project will work within the limits of the MOH national policy while advocating for improved services, especially related to diarrheal disease control. Zinc supplementation has not been included in Malawi's MOH National Policy, and the 'new' ORS packets are not readily available in Malawi. However, the project will raise awareness about the value of zinc supplementation among policy makers and major stakeholders. Because the BCC approach is new to Chitipa, the project is careful to not introduce a 'magic tablet' for diarrheal disease, but focuses on communicating messages regarding diarrhea prevention and early treatment strategies. Because the MOH is not promoting point of use disinfection and because, other than fuel for boiling water, there are no resources (filters, chlorine treatment, etc.) available in Chitipa for water treatment, the project will not focus on it. Should such resources become available; the project will work with MOH to mobilize community to utilize them.

Comment: *HIV seems to be an afterthought to program strategies and is not well explained. There is VCT without access to PMTCT and/or ARVs.*

Response: PMTCT and ARVs are available at the district hospital, and there are plans to expand availability to other health centers.

Comment: *The methodology for implementing PD/Hearth needs to be clarified and elaborated. A 20% LOE attributed to nutrition does not seem realistic given the intensity of effort needed to implement PD/Hearth.*

Response: Please refer to Program Description for a description of the PD/Hearth intervention. Note that the project will focus resources for PD/Hearth by implementing it only in those communities with the highest rates of malnutrition.

Comment: *The application states that UNICEF has offered to work with WR and the district..... This should be documented with a letter of support provided from UNICEF. Discuss any alternative options should UNICEF not be supportive of its commitment.*

Response: The proposed partnership with UNICEF has changed in response to changes in UNICEF's operational strategy. UNICEF now works directly with government establishments including the Ministry of Health at national and district levels, channeling its funds and technical support through them, according to the Sector Wide Approach adopted for decentralization. PVOs in partnership with government establishments then become 'indirect partners' with UNICEF. Specifically, in Chitipa District, UNICEF supports the DHMT especially in immunization and cold chain maintenance, while supporting CBOs and CBCCs through the District Social Welfare Department of the Ministry of Gender and Social Welfare.

UNICEF had offered to work with WR and the district to ensure that HSAs in Chitipa have drug kits in time for program implementation. Because the MOH can access UNICEF funding for immunization support and drug kits, this project need will still be met through the now indirect partnership with UNICEF.

Comment: *The SOL letter (without a date) mentions use of 17 key family practices which are not discussed in the program strategy. It is important to clarify the relationship between the program's technical approach, these 17 key family practices, and their relation to MOH policies and guidelines.*

Response: The SOL letter has been updated; please refer to Annex D. The CSP plans to harmonize its messages with those key family practices commonly promoted by UNICEF and partners working in health in Malawi (including the SOL). Topics in common include exclusive breastfeeding, complementary feeding and sustained breastfeeding, hygiene and sanitation, malaria prevention, HIV/AIDS prevention and care, feeding and giving fluids during illnesses, home health practices, immunization, health care seeking behavior and compliance with treatment/follow-up after referral.

Comment: *The way the volunteers will be recruited, trained and retrained needs to be clarified. Issues around sustainability need to be more clearly addressed. It is recommended that WR consider applying the CSSA sustainability framework in development of this program.*

Response: Please refer to the program description section for discussions of volunteer recruitment, training, and sustainability.

Performance Monitoring and Evaluation

Comment: *The proposed quarterly rapid assessments may prove too burdensome and be too frequent to detect useful change given the impact nature of most of the indicators. While utilization data will only serve as a proxy for the indicators the project is seeking to measure, it might be more realistic to use utilization data to monitor progress frequently, and to decrease the LQAS to bi-annually, or even less often.*

Response: Local Rapid Assessments will be conducted at the completion of each intervention (approximately quarterly) until all interventions have been phased in. This helps to monitor uptake of information at the household level and correct for problems while still early in the project. The LRAs will become less frequent (biannually) in the last 2 years. Please refer to the work plan for illustration.

Comment: *WR should consider integrating any existing MOH indicators and data in its M&E plan to create greater linkages between partners and to demonstrate the project's applicability and replicability for scaling up.*

Response: CSP data will be integrated into the MOH existing database, and discussions with the district statistician are ongoing. World Relief and the MOH are also exploring the possibility of incorporating the vital events information collected by CG volunteers (outside MOH indicators) into the existing system.

Comment: *The malaria treatment objective refers to treatment at a HF. There will be need to be an objective related to encouraging home case management and treatment in uncomplicated cases.*

Response: The MOH does not currently allow home treatment of malaria. First aid home treatment for fever in children and recognition of danger signs are included in the IMCI curriculum the project is implementing. WR will advocate that the MOH make at least first line anti-malarials available at the community level. Some parts of the project area do have access to such treatment at health posts through HSAs, who can treat uncomplicated malaria, but not all areas have HSAs. MOH plans to make HSAs available in all areas have been in place for several years, but progress has been slow.

Comment: *It may be useful to add an indicator to reflect linkages between health centers and their communities, since this is one of the sustainability elements.*

Response: One of the sustainability indicators the project will measure is the percentage of HSAs trained by the project, to reflect linkages between health centers and their communities. The project will begin measuring sustainability indicators in the second year. Please refer to the program description section for more information regarding sustainability.

Comment: *The OR on the welfare of orphans could potentially impede the other child health interventions or distract the work of the Program Manager. Since this might not be considered critical for this project, WR should consider moving it to the second half of the grant period, or to a separate setting.*

Response: The project has revised the plans for OR, as described earlier in this section.

Management Plan

Comment: *This section would be strengthened with more elaboration of the HSA role and how they will be collaborating with and supported by the project promoters.*

Response: Please refer to the program management section for a description of the role of HSAs.

Comment: *Management staff in the field will need access to financial information for decision making.*

Response: The field budget is available to staff, and the country finance manager works closely with the CSP Directors, account assistant and office assistant UNICEF in Mzuzu and Chitipa in the development and implementation of the program budget.

Comment: *Since the WR Drug Revolving Fund (DRF) activities link with the UNICEF supported community drug kits coming to the district, the work plan should reflect this activity, eventually with dates.*

Response: The DRF scheme is a Government of Malawi initiative which is undergoing revisions at the moment. WR will continue working with the MOH to ensure access to essential drugs, at least at the Health Center level. Although still in place at the moment, the government plans to eventually, replace the DRF scheme with the essential health package.

Collaboration

Comment: *It will be important to align the program with the most recent version of the Mission's health SO and IR statements.*

Response: The most recent versions (2001 – 2005) were referenced in the proposal; they are currently under review and the new versions are pending. Final drafts were not available before June 30th, 2006 (when the final DIP was due), but project leadership will obtain a copy as soon as the SO and IR statements are finalized, and every effort will be made to align the project with them.

E1. Program Site Information

Country Profile

Malawi is a landlocked country in Southern Africa, bordered by Mozambique to the east and the south, Tanzania to the north and Zambia to the west. Please refer to Map in Annex B. Malawi's total population is estimated at 12.1 million, with almost half (47%) of its population under 15 years of age and about 20% under five years of age^{xii}. Sixteen percent of the people live in urban areas^{xiii}, and literacy rates for adult males and females are 88% and 67% respectively^{xiv}. Malawi is ethnically diverse, with Tumbuka, Chewa and Yao as the three major ethnic groups, and 12 smaller groups and languages^{xv}. Total fertility rate remains high at 6%, though lower than the 6.7% reported in 1992^{xvi}. Malawi's economy is heavily dependent on agriculture, which accounts for more than 90 percent of its export earnings, contributes 45 percent of gross domestic product (GDP), and supports 90 percent of the population^{xvii}.

Despite decades of donor support, Malawi remains one of the poorest countries in the world, ranking 165 of 177 nations on the human development index, GDP per capita rank of 176 of 177 nations^{xviii}, and 65% of the population living in poverty^{xix}. Life expectancy at birth for Malawians is 42 years, one of the lowest in non-war ravaged nations of the world, with U5MR of 133 per 1000 live births and IMR of 76 per 1000 live births, an improvement from the IMR reported in the 2000 DHS of 104 per 1000 live births^{xx}. The preliminary 2004 DHS notes that similar declining mortality rates have been recorded in neighboring countries. Most under-five deaths are due to malaria, pneumonia, diarrhea, measles and malnutrition and often a combination of these^{xxi}. However, in the past five years, the infant and child mortality rates have reduced from 112 to 76 per 1000 live births and from 187 to 133 per 1000 live births respectively^{xxii}, but they still remain unacceptably high. The MMR is 985/100,000^{xxiii}, due mainly to poor access to antenatal care, lack of assistance from trained health personnel at delivery, and high prevalence of anemia which worsens the outcome of pregnancy and delivery for both mother and child. Overall, 45% of women in Malawi are anemic, with rural women and those with less education being more likely to be anemic than

^{xii} National Statistical Office Malawi – Population Projections from 1998 Census

^{xiii} National Malaria Control Program Strategic Plan 2005-2009

^{xiv} Malawi Preliminary DHS 2004

^{xv} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{xvi} Malawi Preliminary DHS 2004

^{xvii} Malawi World Bank Group Country Brief accessed March 29, 06 at

www.worldbank.org/wbsite/external/countries/africaext/malawiextn

^{xviii} Human Development Report 2005

^{xix} Malawi Poverty Reduction Strategy Paper, 2002

^{xx} Preliminary DHS 2004, DHS Malawi 2000 Final Report

^{xxi} Malawi Ministry of Health IMCI Draft Policy, January 2006

^{xxii} Malawi Preliminary DHS 2004

^{xxiii} Malawi Preliminary DHS 2004

other women^{XXIV}. Although 93% of mothers received some antenatal care during their most recent pregnancy, only 57% of births are attended by trained health professionals^{XXV}.

Malaria, pneumonia, malnutrition, diarrheal disease, AIDS and TB account for 70% of inpatient deaths in Malawi^{XXVI}. Though these are readily preventable and treatable diseases and illnesses, cultural beliefs and practices, poor access to health facilities, and a shortage of trained health personnel, amidst other factors, make these diseases major threats to child survival in Malawi. Malaria alone accounts for 36% of pediatric outpatient clinic attendance, 40% of all under-five (U5) hospitalizations, and 40% of U5 hospital deaths^{XXVII}. It is the single leading cause of hospital admissions among under-fives. Multi-drug resistance to common anti-malarials has warranted the switch to more expensive combination therapies, further escalating the problem of access to affordable malaria treatment. Malawi's adult HIV/AIDS prevalence rate is significant at 14.2%, with about 900,000 people living with HIV/AIDS^{XXVIII}. HIV/AIDS is the leading cause of death in the reproductive age group^{XXIX} and is predicted to orphan over half a million children below 15 years by 2003^{XXX}.

The effects of household insecurity, poor health practices and HIV/AIDS are reflected in the malnutrition statistics for Malawi. The nutritional status of children has improved very little since 1992, with an estimated 48% of under-fives suffering from moderate and severe stunting, 25% underweight, and 6% wasted^{XXXI}. Children living in rural areas are more susceptible to malnutrition than those in urban areas^{XXXII}.

A follow up survey on family care practices that promote child health and development (UNICEF, 2004) revealed that 60% (163,000) of under-five deaths are occurring at home^{XXXIII}. The main contributing factors include distance to health facilities, poor health care seeking behavior, poor hygiene practices and non-compliance with health worker advice^{XXXIV}. Health and social practices are strongly influenced by traditional customs and beliefs, though over 96% of the total population is Christian^{XXXV}. Rural dwellers have limited access to social and health facilities and consequently have poorer social and health status compared to urban populations, especially among women and children under-five. The nation's dependence on agro-economy makes it highly vulnerable to droughts and other natural disasters that result in acute food shortages. This contributes to the high malnutrition rates, and hence, high disease burden reported among children under five. Several factors (including those highlighted above) contribute significantly to the poor health status of women and children in Malawi in general, and Chitipa in particular.

^{XXIV} Malawi Preliminary DHS 2004

^{XXV} Malawi Preliminary DHS 2004

^{XXVI} Malawi DHS 2000

^{XXVII} Malawi National Malaria Strategic Plan 2005-2010

^{XXVIII} UNICEF: www.unicef.org/infobycountry/malawi_statistics.html

^{XXIX} Malawi National AIDS Commission 2003

^{XXX} UNICEF, 2004

^{XXXI} Malawi Preliminary DHS 2004

^{XXXII} UNICEF, 2004

^{XXXIII} Malawi Ministry of Health IMCI Draft Policy, January 2006

^{XXXIV} Malawi Ministry of Health IMCI Draft Policy, January 2006

^{XXXV} Chitipa District Socio Economic Profile. Republic of Malawi October 2002.

Factors such as poverty, limited access to existing health services and low level of knowledge of health practices contribute to the increased vulnerability of the population, especially children and women, to readily preventable diseases and illnesses.

Chitipa: Malawi is divided into southern, central and northern regions, and twenty-eight administrative districts. Chitipa District is located in the northeast of the northern region, and is the northernmost and most isolated district in Malawi. It is about 400km (248 miles) from Mzuzu, Northern Regional Headquarters, and about 700km (435 miles) from Lilongwe, the nation's capital. The District has two international borders – Tanzania to the north and Zambia to the west. It also shares boundaries with Karonga District in the northeast and Rumphu District in the south. The topography of the district is largely mountainous, with Chitipa's estimated 174,786 people scattered over the mountains in 475 villages. According to a census conducted by the project in January 2006, there are 32,025 children under age five (18% of total population) and 40,201 women of reproductive age (42% of total population) in a total district population of 174,786. These calculations are similar to national estimates in the 2004 DHS, where children under five make up 18.4% of the total rural population and women 15-49 equal 39.1% of the same.

A large fertile plain of Chitipa is known as the breadbasket of the district, with approximately 8700 hectares of rich arable land. This is cultivated mainly for subsistence crops during the rainy season. However, food production is seasonal with most of the population insecure between November and February, the planting season. Women and children are particularly vulnerable during this period as intra-household food distribution favors men. The district's geographic isolation, mountainous terrain, high poverty rate, and limited access to resources render its population highly vulnerable to preventable infections and diseases.

Health Profile

Surveillance data are reported monthly by HSAs to Health Facilities which in turn submit monthly reports to the District Statistician for inclusion in the District database. Copies of the compiled data are sent monthly to a central database. Surveillance reports are collated quarterly and circulated to local, regional and national MOH authorities, as well as shared with HSAs, community leaders and Village Health Committees to inform decision-making, responses to outbreaks, etc.

A gamut of health information is collected, including in-patient and out-patient services, in-patient morbidity and mortality, community based data, personnel status and movement, and stock-outs for essential drugs. Coverage is incomplete, with 6 out of 8 Health Centers reporting. Areas not covered by HSAs do not have up to date information, and outreach immunization data is not accurate due to staff shortages. Household level data is largely unavailable.

The most recent quarterly District report available covers the period from July through September, 2005. The report shows 86.6 under-five malaria cases/1000 population, 37.6 under-five cases of malnutrition/1000 population, and 54.8 ARI cases/1000 population.

Other information collected includes FP, ANC, delivery outcomes, EPI, STI, cholera, Acute Flaccid Paralysis, and general morbidity and mortality data.

Malaria: Malaria is a major burden to Malawi in general and to Chitipa District in particular. Malaria is the leading cause of U5 morbidity and mortality in the country, causing 40% of all U5 hospitalization and 40% of U5 hospital deaths. Thirty-seven percent of all recorded deaths in Chitipa were attributed to cerebral malaria^{xxxvi} in 2000-2001. The latest Chitipa MOH surveillance data for under-fives reported 86.2 cases of malaria/1000 population during the 3 month period. It is known that over 50% of malaria cases in Malawi do not receive treatment at HFs^{xxxvii}. Findings from baseline studies conducted in Chitipa regarding caregiver knowledge indicate that a good proportion understand that mosquitoes bring malaria at night, but quite a number do not understand the link between bed nets and malaria^{xxxviii}, and beliefs linger regarding transmission to humans from evil spirits, bad water and unhygienic practices.

Access to treatment and care-seeking for malaria is poor. Baseline KPC findings report that only 17.5% of children 0-23m with fever in the two weeks preceding the survey received treatment at a HF within 24h of onset of the fever. In addition 82.5% of mothers would seek treatment for symptoms of malaria *after* 24hours of onset of symptoms, whereas WHO recommends treatment *within* 24 hours. Reasons for this delay include distance from the health center, belief that malaria is caused by evil spirits, and the long waiting periods at HFs. A joint survey conducted by WHO, UNICEF and MOH reported that 72% of families first use home-based treatment for their children before taking them to a HF, and 30% of febrile children who were not taken to a HF received no medication^{xxxix}. Unfortunately, only 47% of malaria cases seen at HFs are managed appropriately.^{xl} Reasons identified for this pattern include traditional beliefs and economic barriers. Although treatment in public health facilities in Malawi is free, long waiting times and poor attitudes of HF staff constitute barriers to health service utilization.

Nationwide, only 42% of households have at least one **bed net** (only 27% have ITNs), with an average of 0.7 nets per household, but only 27% of U5s and 20% of WRA slept under a bed net the night prior to the DHS survey^{xli}. In the Northern region, 47% of households possess at least one bed net; 32% of U5s and 23% of WRA slept under a bed net the night preceding the DHS survey^{xlii}.

Over 85% of malaria infections are due to *Plasmodium falciparum*, but **resistance to anti-malarial drugs** has posed a major threat to malaria treatment in Malawi. Though Malawi adopted SP as the first line treatment of malaria in 1993, resistance to SP has increased to 25-

^{xxxvi} Chitipa District Socio Economic Profile. Republic of Malawi October 2002.

^{xxxvii} Malawi National Malaria Control Program Strategic Plan 2005-2009

^{xxxviii} Child Survival Program Focus Group Report, 2006

^{xxxix} Household Baseline Survey for Family and Community Child Key Care Practices in selected Districts in Malawi: MOH, UNICEF and WHO, 2000.

^{xl} WHO Southern Africa Malaria Control Program report baseline 2001

^{xli} Malawi Preliminary DHS 2004

^{xlii} Malawi DHS 2004

31% by 2004 (report from 6 sentinel sites)^{XLIII}. Currently, the MOH is planning to change to combination therapy which is more expensive and therefore less accessible to the larger populace. Only one in five U5 children and pregnant women have access to prompt and appropriate treatment and about one-third of pregnant women receive IPT.^{XLIV}

Maternal morbidity in Chitipa arises mainly from malaria, anemia and emergency obstetric complications^{XLV}. MOH policy recommends two doses of SP in pregnancy, to minimize the adverse effects of malaria in pregnancy.

Pneumonia is a leading cause of U5 morbidity and mortality in Malawi, with 1.26 million episodes per year, accounting for 12% of U5 illnesses. Nationwide, ARI accounts for 23% of in-patient deaths^{XLVI} and only 18% of children with ARI were taken to a HF for treatment^{XLVII}. Access to care is limited by the same factors that impede care for malaria and other common childhood illnesses. These obstacles include distance, with many households being over an hour's walk from a facility (in some instances 40hours), cost, related to time lost waiting to be seen by HF staff (services are free of cost).

Diarrhea is a leading public health risk to families, especially children under five years. Children suffer an average of five diarrheal episodes per year.^{XLVIII} Two week prevalence for diarrhea was reported to be 18% in U5 children and 36% in infants 6-11 months^{XLIX} in 2000. Diarrhea is seasonal, peaking from December to April and lowest during July and August^L. Preliminary results of the 2004 DHS survey report that 61% of children with diarrhea in the 2weeks prior to the survey received an ORS packet, 70% received ORT, and 33% were taken to a HF for treatment^{LI}. FGD findings reveal that diarrhea is a common child health problem in most communities in Chitipa. In Chitipa District, 78% of the population has to travel over 20 minutes to a safe water source, with worse rates in Wenya and Mwaumbamba areas of Chitipa^{LII}. Over 70% of households in the district have access to a latrine, but improper disposal of waste continues to be a major challenge to sanitation in the district^{LIII}.

Malnutrition is endemic in Malawi, with 70% of U5 children chronically malnourished, 48% stunted, 22% severely stunted, and 5% wasted^{LIV}. Malnutrition rates have remained

^{XLIII} Malawi National Malaria Strategic Plan 2005-2010

^{XLIV} Global fund for AIDS, TB and Malaria

^{XLV} Chitipa District Socio Economic Profile 2002. Republic of Malawi October 2002.

^{XLVI} National Statistics Office [Malawi] and ORC Macro. 2001. Malawi Demographic and Health Survey 2000.

Zomba, Malawi and Calverton, Maryland, USA: National Statistics Office and ORC Macro.

^{XLVII} Malawi Preliminary DHS 2004

^{XLVIII} Malawi Health Management Information Bulletin. Special Issue 2002. Ministry of Health and Population Planning Department, Health Management Information Unit. June 2003.

^{XLIX} National Statistics Office [Malawi] and ORC Macro. 2001. Malawi Demographic and Health Survey 2000.

Zomba, Malawi and Calverton, Maryland, USA: National Statistics Office and ORC Macro.

^L Malawi Health Management Information Bulletin. Special Issue 2002. Ministry of Health and Population Planning Department, Health Management Information Unit. June 2003.

^{LI} Malawi Preliminary DHS 2004

^{LII} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{LIII} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{LIV} Malawi Preliminary DHS 2004

stable in Malawi over the last two decades^{LV}. Exclusive breastfeeding rates for children under six months are 53%^{LVI}, and 75% of under two month olds are exclusively breastfed. Complementary feeds are introduced early, though most children are still breastfeeding at 12 months of life^{LVII}. Complementary foods are generally of poor quality, and consumption of proteins, vitamin A- and iron-rich foods is uncommon^{LVIII}. Micronutrient deficiencies are prevalent in Malawi, with 68% of U5s affected by anemia and 45% of women are anemic^{LIX}. Causes of malnutrition in Malawi include household food insecurity, poor weaning and feeding practices, and recurrent infections. Salt iodization is not universal in Malawi, with 59% of households having iodized salt^{LX}.

Immunization: Malawi has experienced a steady decline in immunization coverage rates over the last two decades, with rates of 64% for children 12-23 months with full immunization status, compared with 82% and 70% in 1992 and 2000 respectively^{LXI}. This is true for all types of vaccines. Baseline KPC finding revealed a measles vaccination coverage rate of 55% for children 12-23 months in Chitipa. In 2002, immunization coverage in Chitipa rose from 58% to 100%, through UNICEF's support of the cold chain system; but since UNICEF direct cold chain assistance declined, coverage rates have dropped significantly. Nationwide measles mop-up campaigns were conducted December 2005 to improve overall coverage for under-twos. Maternal tetanus toxoid vaccination coverage rates stand at 85%, similar to rates recorded in 1992 and 2000 DHS surveys^{LXII}.

HIV/AIDS: Malawi's national adult HIV/AIDS prevalence (14.2%) is one of the highest in sub-Saharan Africa, a situation worsened by poverty, ignorance of methods of preventing infection, harmful traditional practices, and stigmatization. Though knowledge of HIV/AIDS is near universal among adult Malawians^{LXIII}, only 30% of women and 47% of men used condoms during sexual activity with non-cohabiting partners^{LXIV}. Only 8% of women and 16% of men reported that they had been tested for HIV. Voluntary Counseling and Testing (VCT) sites are available at all HCs in Chitipa, and ARV therapy and PMTCT services are available at the District Hospital. In 2000, one-third of women with STI in Northern Malawi received treatment from traditional healers, another one-third from friends or relatives, 19% from drug vendors, and only 22% from a HF^{LXV}. Approximately 70,000 children under 15 years are infected with HIV/AIDS; and about 500,000 children under 18 years have been orphaned by AIDS^{LXVI}, with over 11,000 children under 15 years having lost one or both parents, half of them due to HIV/AIDS. Chitipa District Social Welfare Department is developing a strategic plan to address the needs of orphans and vulnerable children in

^{LV} Malawi Preliminary DHS 2004

^{LVI} Malawi Preliminary DHS 2004

^{LVII} Malawi DHS 2000

^{LVIII} Malawi DHS 2000

^{LIX} Malawi Preliminary DHS 2004

^{LX} Malawi DHS 2000

^{LXI} Malawi Preliminary DHS 2004

^{LXII} Malawi Preliminary DHS 2004

^{LXIII} Malawi DHS 2000

^{LXIV} Malawi Preliminary DHS Report 2004

^{LXV} Malawi DHS 2000

^{LXVI} The Republic of Malawi National Plan of Action for Orphans and Vulnerable Children 2005 - 2009

Chitipa, drawing from the National Plan of Action developed by the National Ministry of Gender and Social Welfare in conjunction with UNICEF. The Social Welfare team coordinates the activities of all organizations involved in orphan care: UNICEF in Kameme, LISAP, and other faith-based organizations.

Chitipa's economy, like most of Malawi, is agri-based, with subsistence farming being the major source of income for majority of the families. Tobacco and coffee are grown by 4% of the population as cash crops, but markets are limited by Chitipa's isolation from the rest of Malawi and poor road networks. Acute food shortages occur during the planting season, in the months of November through February. During these months people sell livestock, firewood and traditional beer to sustain their households. Lack of modern farm tools and inputs (due to the poor road network which isolates Chitipa) also limits the performance and yield of farmers.

Between 55 -75% of Chitipa dwellers live below the poverty level^{LXVII}. A small proportion of the population is self employed, in small and medium scale enterprises, and a smaller proportion is employed in the civil service. Though there are more women than men in the District, most of the commercial and economic activities are male dominated. Few women participate in community development meetings and activities, because the communities are dominated by men^{LXVIII}.

Due to the limited opportunities to earn a living in Chitipa, many young men migrate to Zambia to work in the mines, as well as to Tanzania to seek employment. This movement, which is associated with risky sexual behavior including interaction with the commercial sex industry, contributes to HIV/AIDS infection.

Malawi's ethnic diversity is reflected in Chitipa, with 15 ethnic groups, and almost as many languages. Chitipa is predominantly Christian (96%), 1% Muslim, and 2% with no religious affiliation. The project will work with Christian churches to reinforce health messages, although care is taken to ensure that the entire population of Chitipa is included in the project, regardless of religious affiliation.

While literacy rates in the northern region are higher than those of other regions^{LXIX}, Chitipa has the lowest adult literacy level of all the districts within the northern region. Males receive more years of education than females. In the northern region, adult male literacy rate has been measured at 76%, and the adult female literacy rate has been measured at 68%^{LXX}. The society is patrilineal, and the status of women is extremely low. Women are expected to move to their husbands' village, and the husband's parents pay a dowry for the bride. Household decision making falls squarely on men and grandmothers^{LXXI}.

^{LXVII} Malawi Poverty Reduction Strategy Paper, 2002

^{LXVIII} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{LXIX} 1998 Population and Housing Census Final Report, National Statistical Office of Malawi

^{LXX} 1998 Population and Housing Census Final Report, National Statistical Office of Malawi

^{LXXI} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

The poor road network and Chitipa's remote and mountainous location present a number of challenges to the project, including communication limitations and difficulty accessing parts of the population, particularly during the rainy season. At present, few phone lines are available and internet access is even harder to come by. The project has not yet been able to secure a phone line in Chitipa, but every effort is being made to do so as soon as possible. The project has increased the number of volunteers because of the distance and difficult terrain between households in some areas.

Chitipa's widely dispersed population is organized into a large number (475) of villages, some of them made up of 10 household or less. Each village has headmen with whom the project must engage to ensure buy-in and support.

Security is also an issue, with theft becoming increasingly common and accounting for 58% of all crimes committed in 1999^{LXXII}. There is only 1 police officer for every 2,350 people in Chitipa, which partly explains why the number of crimes remains steady despite efforts to curb offenses^{LXXIII}. Additionally, proximity to poorly patrolled international borders contributes to theft, as stolen goods are particularly difficult to track down once they have crossed the border.

The project's health education messages will challenge certain traditional beliefs. One example with relevance to the nutrition intervention is the *chiyungwa* belief. Nutritious pumpkin leaves may only be taken at the directive of a Traditional Authority or Village Head, usually at a certain time of year. The belief is that the person who eats the leaves without authorization will likely be struck by lightning. The project will approach interventions that challenge such beliefs with great sensitivity and respect.

Health System Capacity and District Health System

Malawi's health system is managed at the federal, provincial and district levels. In general, health services are provided by 3 main agencies: Ministry of Health 60%, Christian Health Association of Malawi 37%, Local Government 1%, and others (private hospitals and clinics, commercial companies, the Army and Police)- 2%^{LXXIV}. The non-formal health sector includes a large and active traditional health sector in Malawi, as evidenced by the 75,000-member Herbalist Association of Malawi, private drug vendors who sell basic drugs and TBAs. TBAs have more established links with the modern health sector, as some have received training and the estimated 18,000 TBA in 1995 performed 23% of deliveries.^{LXXV}

The private sector is the largest source of health finance, accounting for almost 45% of the sector's total, and donors providing a third. Household health expenditure accounts for over one fourth of the financial sources in the health sector. The per capita total expenditure on health was

^{LXXII} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{LXXIII} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{LXXIV} Malawi National Malaria Control Program Strategic Plan 2005-2010

^{LXXV} Malawi DHS 2000

US\$13 in 2001, while the per capita government health care expenditure was US\$4^{LXXVI}. Health expenditure represents an intolerable burden for Malawi's poorest.

Chitipa District's formal health system includes 33 health posts, 45 outreach clinics, 8 health centers and 1 district hospital. The MOH operates all but two of the health centers, which are run by religious missions but supervised by the District. These centers provide family planning, safe motherhood, environmental health, immunization, disease prevention, ANC, and GMC and promotion services, at no cost to users. Cost sharing mechanisms that have been attempted through user fees have faced challenges in ensuring quality and determining exempt criteria for the poor. Patients are referred to the district hospital for c-sections, surgery, nutrition rehabilitation, and VCT. Lack of adequate staffing in the district health system poses a great challenge to the district. CHAM health centers and posts charge nominal fees for services. SOL plans to add 3 HF in Chitipa, services that would be complemented well by the community education provided by the project, which will create demand for services. Although 85% of Malawi's population lives within 8km of a HF, limited staffing, drug and equipment supply result in suboptimal performance of the health system^{LXXVII}.

There is an average of 1 bed to over 900 population in Chitipa, with a range from 1 bed to 267 population Mwalumbambya TA to 1 bed to 2067 population in Misuku TA^{LXXVIII}. The trained health personnel to population ratio is also very low, with one clinical officer to over 25,000 population, one nurse to 3,000, one health assistant to 14,000 population and one HSA per 2000 population^{LXXIX}.

Malawi's MOH promotes an essential health care package (EHP) focusing on common illnesses and equitable to the poor using a sector wide approach. It emphasizes ITN distribution and use, increased access to prompt treatment within 24h for children, and increased access to IPT. Effective implementation of the EHP requires considerable effort in strengthening the health infrastructure to ensure optimal performance. Several changes have been instituted to improve the performance of the health system, including decentralization, private sector involvement, improving drug supply and availability, quality of health service supply and community participation^{LXXX}.

The IMCI strategy was adopted in Malawi in 1998 as a strategy to promote child health, with technical support from WHO and UNICEF. By the end of 2005, IMCI had been implemented in 18 of 28 districts, with 10 districts implementing all three components of IMCI, 8 implementing components 1 and 2, and 1 implementing only component 3. Eight districts have yet to formally implement IMCI. In the districts where components 1 and 2 have been implemented, 60% of health workers have received IMCI protocol training^{LXXXI}. In Chitipa, all HF clinicians have received IMCI training, and implementation is ongoing. Overall, the focus has been on promoting key family practices but little attention has been

^{LXXVI} World Health Report 2004, WHO

^{LXXVII} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{LXXVIII} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{LXXIX} Chitipa District Socio Economic Profile. Republic of Malawi October 2002

^{LXXX} Health Information System: National Policy and Strategy, Malawi Government Ministry of Health and Population 2003

^{LXXXI} Malawi IMCI Policy Final Draft January 2006

paid to building partnerships between health facilities and communities or improving the community's access to appropriate health care and information. The project will advocate that the MOH address these issues.

The MOH promotes 17 key family practices, 16 developed by UNICEF with 1 MOH addition regarding OVC care^{LXXXII}. Below are the Key Family practices that relate to the project interventions.

Key Family Practices:

- Exclusive breastfeeding
- Complementary feeding and sustained breastfeeding
- Hygiene and sanitation
- Malaria prevention
- HIV/AIDS prevention and care
- Feeding and giving fluids during illnesses
- Home health practices
- Immunization
- Health care seeking behavior
- Compliance with treatment, follow up and referral

The Government of Malawi initiated the decentralization process in 1999, and has devolved central administration authority to Districts to allow for greater autonomy and micro-planning and implementation. The Central Government devolved power and functions of governance and development to elected Local Government Units, called District Assemblies composed of elected councilors Traditional Authorities, Members of Parliament and five representatives of special interest groups. District Assemblies are required to develop action plans and annual plans for their district, with a time line and budget for all activities. The central government contributes a percentage of its national revenue to local governments, but the district is allowed to raise additional revenues by levying local taxes. Local agencies at the district and local levels are integrated into one administrative unit and implementation responsibilities are transferred to District Assemblies.

An essential element of this new redistricting is that the district MOH, which had operated fairly autonomously at the local level and had reported directly to the central MOH, will now be administered by the District Assembly headed by the District Commissioner. This means that the district health officer, in addition to reporting technically to the central MOH (through the regional MOH), will report administratively to the district commissioner and locally-elected Members of Parliament (MPs). This should ensure greater community participation and involvement in health, as locally-elected MPs will be evaluated and elected according to their support for a variety of social services, including health. Each Assembly is required to produce a Decentralization Implementation Plan (DIP) that outlines areas of focus for implementation and resource requirements.

^{LXXXII} A Malawi HRAP C-IMCI Case Study, UNICEF, GoM, DIFD, May 2003

With the decentralization of health services and the introduction of DIP at district level, malaria control has now been integrated into the general disease programs with the DHO as the overall in charge in accordance with the Sector Wide Approach (SWAP)^{LXXXIII}.

Access to Health Services and Care-seeking Practices

Transportation in Chitipa is poor, with limited accessibility during the rainy season, and motorized transportation is often unavailable in rural areas. Traveling to the District Hospital presents a formidable challenge to isolated communities in the northern mountains. Though outreach clinics are conducted all over the district, other preventive and curative services are not readily accessible. People living in Chitipa must travel further to the nearest HF than in any other district in Malawi.^{LXXXIV} Seventy percent of Chitipa District's population must travel more than 5km to a HF. Those in the extreme north areas of Musumbe and Nthalire often travel further, some up to 40 hours to the central district hospital.^{LXXXV} Very recently, all but one HC in Chitipa have obtained an ambulance to transport patients. Other means of transport are by foot, stretcher, oxcart or bicycle. In addition, functioning radios are available at all MOH Health Centers and in ambulances, facilitating communication and prompt case referrals. Some health centers have fixed phone lines, but cell phones are not readily available in Chitipa because of poor network and connectivity.

A UNICEF study found that over half (54%) of child deaths in Malawi take place at home and one in four children have no contact with a HF before their deaths. Parents cited distance (48%), quality of care (34%) and cost (30%) as reasons for not accessing care.^{LXXXVI}

Focus group findings in Chitipa (2003) validated the practice of seeking health care services from traditional healers as the first line of treatment and HF as a second choice, while grocery or medicine shops, clinics, churches (for healing prayer), and Drug Revolving Fund (DRF) volunteers were other sources named. Traditional healers, found in most villages, are sought after for treatment of common illnesses including pneumonia, malaria, diarrhea and convulsions, and they usually receive payment in-kind.

Respondents in the focus groups and in-depth interviews conducted during the project's formative research identified a number of needy groups, including very old people, orphans and people with physical disabilities and chronic illnesses. Respondents reported that some, but not all, needy individuals receive support from churches, NGOs, government and other structures within the community.

Partnerships and Role of other Agencies: WR, in partnership with the District MOH and SOL as the leading church partner, will seek areas of collaboration with other agencies and

^{LXXXIII} Malawi National Malaria Control Program Strategic Plan 2005-2010

^{LXXXIV} Malawi National Health Plan 1999-2004, Vol. 2: National Health Facilities Development Plan, November 1999, Ministry of Health and Population, Malawi.

^{LXXXV} Report on a rapid appraisal of the health situation of Musumbe and Nthalire, Two peripheral areas of Chitipa District in the Northern Region of Malawi. Church of Central Africa. Presbyterian, Synod of Livingstonia, Mzuzu, Malawi: March 2001.

^{LXXXVI} Wasnsi, E.; Mtango, D.; Maganga, E.; Banda, E.; Msiska, T. Community IMCI Baseline Survey in Malawi. UNICEF, WHO, Government of Malawi, 2001.

organizations to avoid duplication of efforts and facilitate knowledge sharing and exchange of ideas. Other main players that have been identified as collaborators include:

1. **World Vision Malawi:** area development program (ADP) activities include health infrastructure rehabilitation and construction, but primarily focused on food security issues.
2. **CADECOM (Catholic Development Commission)** – Nutrition rehabilitation programs, micro-enterprise development, and relief activities related to food shortages
3. **ActionAID:** Works from Mzuzu office (no office in Chitipa), and is focused on HIV/AIDS activities, although impact in Chitipa is limited. However, ActionAID has funds for OVC care, and WR will explore possible opportunities of tapping into this fund for OVC support in the future.
4. **CCAP (Church of Central Africa Presbyterian a.k.a. Synod of Livingstonia, or SOL)** - has 2 health centers (with plans to increase the number), and church based HIV/AIDS, malaria control and other programs.

Table 2: Role of Agencies Currently Operating in Chitipa

<i>Agency</i>	<i>Activities in Chitipa District</i>
UNICEF	OVC care, MOH capacity building for: EPI, C-IMCI, Malaria control, DRF
SOL	Water and sanitation, ITN committees, HIV/AIDS
World Vision	Food Security and Community Development
CADECOM	Home-based care for HIV/AIDS patients
Red Cross	Food for work
PSI	ITN marketing to MOH
Action Against Hunger	Hospital-based nutrition rehabilitation
Action AID	HIV/AIDS activities for youths
Banja La Mitsogolo	Family Planning

Other PVOs that operate in Chitipa cover very limited geographic sub areas. PSI doesn't have an office in Chitipa, but markets ITNs to the MOH, which in turn makes ITNs available to the public through health facilities and community ITN committees. The CCAP operates 2 health facilities and has churches throughout Chitipa district, some of which are involved in water and sanitation programs (Nthalire, Central, and Misuku areas), HIV/AIDS, congregational ITN committees in Musumbe; and also a health post in Musumbe.

World Relief has no other ongoing programs in Chitipa, though plans to implement HIV/AIDS prevention programs are underway through funding from NAC.

E2. Summary of Baseline and Other Assessments

Quantitative and formative research was conducted to obtain baseline information on beliefs and care seeking practices of Chitipa inhabitants. A Knowledge, Practice and Coverage (KPC) survey was conducted by CSP and MOH staff in April 2005 to examine care seeking practices, health service utilization and prevalence of childhood illnesses in Chitipa District. The instrument was developed from the KPC2000+ Toolkit and Rapid CATCH and

translated into the local *Chitumbuka* language. The questionnaires were administered by trained enumerators to mothers of children under two years of age. Women from 300 households were selected using the 30-cluster sampling methodology as described in Annex C. As KPC guidelines were updated after 2005 survey completion, the project team discovered that 3 Rapid Catch Indicators had not been measured according to the current standard, and further information about household practices was gathered during another survey in April 2006. Results from the 2006 survey were very similar to those found in 2005, which was expected, as no interventions other than malaria and pneumonia had been implemented in the interim. Data collected in both surveys were tabulated and analyzed using Epi Info by project and MOH staff.

A summary of survey results and project indicators is provided in Table 3 below. Baseline KPC findings reveal that 85% of children U2 reported an illness within the 2 weeks prior to the survey, but only 17.5% of those with fever visited a HF within 24 hours of onset of symptoms. Mosquito net (treated and untreated) utilization rates are low (37% and 41% for mothers and children under 2, respectively), though they are available to pregnant women and children under-five at subsidized rates at HFs. Less than 10% of children with diarrhea received increased food and fluids (3.8% and 8.3% respectively) and only 35.1% of caregivers wash their hands before food preparation, feeding their children/eating, after defecation and after handling children's feces. The EBF rate is sub-optimal (40%) and only 45% of mothers reported having initiated breastfeeding within the first hour of delivery.

Immunization coverage rates have declined sharply since data collected at the time of proposal development in 2004, as has been the case nationwide. Only 69% of U2s are fully immunized by one year of age, and even less (55.4%) had received the measles vaccine by 9 months of age. In recognition of this low measles coverage rate, a national measles mop up campaign was organized in December 2005.

Most adults have knowledge of HIV/AIDS disease, with 67.5% of caretakers knowing at least 2 methods of preventing the disease. Seventy three percent of respondents use a modern family planning method, but only 8% utilized FP services at a HF. Most (83%) access services from CBDAs, who provide FP services door to door. Please refer Annex C for full KPC report.

Table 3: Comparison of Project Summary Indicators with Preliminary DHS 2004

Indicators/illness	CSP '05	KPC	Prelim DHS '04*
Percent children with Illness 2 weeks prior to survey	85%		-
Percent children with diarrhea treated with ORT	-		59.9% (U5)
Percent mothers who washed their hands before food preparation, before child feeding/eating and after	35.1%		-

defecation and handling children's feces		
Percent mothers who knew at least 2 danger signs for seeking care immediately	71.1% (U2)	-
Percent mothers who sought treatment from HF within 24h for child with fast/difficult breathing	18%	16.5%**
Percent children who slept under bed net last night	41%(U2)	32.4 %(U5)
Percent women who slept under bed net last night	37%	22.9%
Percent children underweight	30%(U2)	17.7 %(U5)
Percent children 12-23months fully immunized	69%	72.5%
Percent children who received measles vaccination	55.4%	84.9%
Women who received at least 1TT during last pregnancy	76.7%	85.6%
Percent women delivered at a health facility	55%	66.4%

* Northern Region Rates ** Not related to time

Note: Attempts at comparing the project data and latest national data from the preliminary DHS report are limited by the absence of specific data on Chitipa District in the DHS, low representation (13%) of northern region population in the DHS, and significant differences in indicators used. Immunization coverage rates reported from both sources are low, similar to the national picture. Maternal TT coverage rates are higher than child immunization rates at both district and regional levels, but care seeking for ARI is poor at both levels. Proportion of children underweight for age at district level is almost twice the regional level figures, though age groups assessed differ. The underweight rate among under twos is an alarming 30%; the Project will pay attention to educating mothers and caregivers of the importance of optimal infant and young feeding practices in this crucial stage of child growth and development. The project will also engage in advocacy with major stakeholders to ensure a multi-sectoral approach is adopted in addressing this issue. Though child mortality rates have declined in Malawi (mainly due to reduction in neonatal deaths), immunization coverage rates have not improved but have steadily worsened over time. It is difficult to reconcile this picture knowing the impact of timely vaccination on child survival. The Project will work closely with the MOH to evaluate these trends and facilitate the development of measures to ensure that child mortality rates continue to decline while immunization coverage increases.

Formative Research using focus group discussions and key informant interviews was conducted in the communities to obtain information on people's beliefs and perceptions of health, care seeking behaviors and barriers to health service utilization. In collaboration with MOH staff, the project team held focused discussions with eight groups representing different sectors of Chitipa's diverse communities. Specifically, interviews and/or focus groups were held with traditional leaders, traditional healers, traditional birth attendants (TBAs), drug sellers, drug revolving fund committees, church leaders, and members of newly formed care groups that included men, women and youths. In addition, before introducing the malaria and pneumonia interventions, women, men and youths were interviewed in groups to collect specific information about beliefs and health seeking behaviors of people where these two illnesses are concerned.

The Project Director trained the Project and MOH staff on qualitative research methodology, with emphasis on information gathering during FGDs. The team developed a discussion guide together with the Community Development Assistant (CDA) from the Ministry of Gender, Child Welfare and Community Services, and other stakeholders. A team of data collectors including a facilitator/moderator, an observer and two recorders/note takers went out to collect information using pre-tested discussion guides. The discussions were conducted in the local language, *Chitumbuka*, and open-ended questions were used to elicit informative responses from participants. Data were analyzed by project staff, and is summarized below.

Table 4: Local Terms for Common Illnesses in Under-Fives and WRA

Common Illnesses/ Diseases	Local Term
Under-Fives	
Diarrhea	Ukupela
Malaria	Kupya kwamubiri
Malnutrition (Kwashiorkor/ Marasmus)	Kuchepa kwa chakulya mumubili ku bana aba pansi pa myaka
Convulsions	Ivizilisi ku bana
Conjunctivitis	Ivombokoli kuwana wowatakwanisizye ivinja
Scabies	Inyende
Worms	Injoka zya mukasi
Premature weaning	Ukuswinkhula luwiro
Frequent child bearing resulting in lack of child care	Ukupapa awana papipi-papipi nupotwa ukuwapwelera
Women of Reproductive Age	
Malaria	Kupya kwamubiri
Anemia in Pregnancy	Kumala kwa dawa kwa bamama wa nthumbo
HIV/AIDS infection	Amatenda gha Edzi kwa bana aba vinja ukwisikira pansi
Bilharzia	Ingelegheta

Across the district, malaria, anemia, and malnutrition were identified as the most common and most severe problems affecting children under five and WRA. In addition, diarrhea, pneumonia, scabies and a condition identified as *Chituli*, or deformed head, which leads to enlarged spleen or death in children, were further identified as prevailing problems of children under five. Anemia, pregnancy complications and HIV/AIDS were major problems identified in WRA, especially pregnant women. Drug sellers described problems related to health care seeking and health service quality, such as delay in seeking care at HF because of ignorance and poverty and inappropriate treatment at HFs, as the main health problems in Chitipa. TBAs identified delay in seeking care from HFs and HIV/AIDS as the main pregnancy-related health problems. Respondents identified very old people, orphans, people with physical disabilities and chronic illnesses as needy people in the community; some of whom receive support from churches, NGOs, government and other community structures.

Health services are provided by Health Surveillance Assistants (HSAs), HC staff, VHCs, Traditional healers, TBAs, ITN committees, Drug Revolving Fund (DRF) committees, drug sellers, church health programs and NGO activities. However, access to appropriate health services varies widely across the district, with people living around the township having the greatest access, while those in some remote areas are without access to even a Health Post (HP) or HSA. Traditional healers typically treat their patients for three days before considering referral, trying several means and methods of getting the disease under control. Patients are referred to HFs for further evaluation and management only after all efforts have failed, usually by the fourth day.

Although many of the groups acknowledged the importance of prompt care seeking from HFs, they acknowledged that many do not engage in such practice for the following reasons: lack of HFs, long distances from available HF, lack of outreach services in communities with very limited access, and lack of money for transport to HF. There are some illnesses, however, that people believe cannot be treated or cured by HF remedies, but can only be attended to by traditional healers. In some cases, even they cannot provide the needed cure.

Pneumonia is one example of a disease thought not to respond to HF treatment. Pneumonia is widely defined as a condition associated with cough, and caused by witchcraft. Almost all respondents stated that pneumonia arises primarily from witchcraft, and some said that it has no cause other than bewitchment. Therefore, there is no logical reason to take patients suffering from pneumonia to the HF; traditional treatment is the only option. Respondents described the movement of the illness from one part of the body to another, in an effort to evade the traditional healer's treatment. Traditional healers suck blood from the affected chest area and prescribe herbal preparations for further treatment. The disease's ability to evade the treatment sometimes allows it to eventually kill the patient.

Some respondents reasoned that pneumonia is often impossible to treat or prevent, since it's due to witchcraft. Others identified carrying a heavy load as the cause of pneumonia, so they avoid such practices, and, unsure of the best treatment, visit both traditional healers and HFs when symptoms of pneumonia are identified.

Many FGD participants identified mosquitoes as causing malaria, but a significant proportion attributed malaria to drinking contaminated water and walking in heavy rains, having sex with a woman who's mistrusting, changing environment, and drinking water from a different source. As a result of this conflicting knowledge, people are unable to make a logical connection between malaria and mosquitoes, and therefore are less likely to understand the importance of ITNs. Some respondents reported not having ITNs for financial reasons, while others identified lack of availability as their reason for not having an ITN. There have been reports that some men use mosquito nets for fishing (verbal report from NMCP Deputy Program Director), and measures to ensure the nets are used appropriately are being examined. Treatment for malaria, irrespective of causation, is still largely sought from traditional healers. Most participants identified access as the major deterrent to their seeking care from HFs, while others choose traditional treatment methods because they believe they're more effective than services at a HF would be. Traditionally, malaria is treated with cooked herbs/leaves, and by covering the patient with a blanket. Some respondents

identified anemia, convulsion, and death as complications of malaria, but details of how these occur were not provided.

FGD and survey findings have greatly influenced the choice of priority interventions in this program. Additional FGDs will be conducted before each new intervention is implemented to assess beliefs and care seeking practices related to specific interventions and to incorporate the findings into the key messages delivered to mothers.

Health Facility Assessments (HFAs) are scheduled for July 2006, and tools for the HFAs have been adapted using the WHO HFA instruments recently used by the WR Mozambique CSP for its own assessment of health facilities (Please see Annex E. for a copy of instrument).

Potential Constraints to Program Implementation

Remoteness and Topography of Chitipa – because of its remote location, communication with central government, and specifically, the National MOH offices, is a great challenge. This limits access to updated policy, as well as the ability of district staff to participate in meetings and decision making processes. Poor communication facilities further hinder networking ability of Chitipa dwellers and decision makers. The Project's administrative office located in Mzuzu functions as a liaison with regional and national level decision makers, and attempts to minimize the communication gap that exists between the district and other levels of government. The Project is also working hard to ensure the Chitipa Project office has a functional telephone line that will ensure direct communication with Chitipa staff. Internet availability is also being explored for Chitipa. In addition, WR Malawi's HIV/AIDS Program Manager, based in the capital city, will provide support to the CSP by representing the project at important child survival related meetings and policy news and networking opportunities that occur in Lilongwe.

Chitipa's mountainous terrain limits ready access to certain parts of the district, especially during the rains. During heavy rains the Chitipa River readily overflows its bank, oftentimes destroying bridges and property. The district is named after the river, Chitipa, which in literal terms means 'the mad one', because of its unpredictable course and tendency to change course during the rains and destroy homes and structures. The Project has purchased 3 four-wheel drive vehicles to assist staff in reaching communities as they can be particularly difficult to access during the rainy season.

Security – Chitipa has two international borders (Tanzania and Zambia), which make it prone to heavy border traffic at certain times of the year. Both are land borders, with no physical barrier and inadequate police presence, leaving movement across the border, especially into Tanzania, largely unchecked. Car and motorcycle theft have become rampant, with police being unable to recover them once they are taken across the border. To forestall vehicle losses, the project has formed an alliance with police and Traditional Authorities who have authorized frequent patrols around the Project office in Chitipa, and also released their emergency numbers to the project senior staff in case of emergencies. Awareness about appropriate protective measures have also been heightened, with training

on sensitivity to environment and measures to take when suspicious activity is noticed, including in staff orientation materials.

Ongoing decentralization process – national decentralization process is ongoing and devolution of authority has not been fully worked out because roles have not been fully defined. The Project will engage in continued dialogue with the District Commissioner to be abreast with developments in this area, and adapt program implementation in a feasible manner.

Expectation of Community Chiefs and Members - some community Chiefs and members expect the program to provide incentives for them to attend meetings and to support the CGs. Some have demanded cash and in-kind material incentives before they can work with the team. Because the program started in the hungry months, many expect that food relief will be provided to program participants. The program has met with chiefs and community members, church leaders, and other stakeholders in the district to explain its mission and purpose. Consistent reinforcement of the advantage of empowerment and behavior change will be a major strategy the project will adopt in reaching these groups. In addition, the project will encourage champions of ‘true volunteerism’ to educate their colleagues and leaders about the long term benefits of social transformation and development. World Relief regularly encounters resistance to volunteerism in new projects and knows that this is a stage most communities go through as expectations are adjusted to reality. Clear communication is important to ensure that everyone understands that volunteers are not paid.

Poor coordination among donors and NGOs in the community has resulted in competition and duplication of efforts among some entities. The project has begun discussion with the District Commissioner, District Assembly (elected community members) and District Executive Committee (heads of line ministries at district level) on ensuring that community-based programs are well coordinated at the District level, and collaboration is promoted. The project will encourage the District Executive Committee to organize meetings to review the coordination process and facilitate networking among NGOs. The Ministry of Gender and Social Welfare has been mandated to lead NGO coordination, and the project will work closely with them to facilitate the process.

E3. Program Description

Program Goal and Overall Strategy

World Relief Malawi *Tube Poka* Child Survival Program aims to reduce disease burden and mortality in children under five and women of reproductive age by establishing an effective community-based system for implementing C-IMCI using care groups of local volunteers. The Program will be implemented primarily at the community level and is designed to build the capacity of local partners and empower community institutions to sustain Child Survival interventions. WR will provide technical guidance and strategy development, in partnership with local institutions, using an extensive network of volunteers to achieve sustainable program implementation. The care groups of volunteers relate to the government health surveillance assistants in such a way that the strategy is scalable to other districts in Malawi, should the Ministry of Health be so inclined.

The Care Group approach is characterized by an extensive network of 3060 community volunteers trained to provide universal coverage of services to all beneficiary households in Chitipa. CG volunteers conduct home visits, promoting behavior change communication (BCC) for key household practices and prompt care seeking according to C-IMCI guidelines. These volunteers are mentored by local project staff (promoters) and supervised by project supervisors and health personnel skilled in C-IMCI using a cascade approach. One volunteer assumes responsibility for his/her immediate ten to fifteen households, training mothers and caretakers on key messages related to specific interventions (described later), at least once every two weeks. Ten to fifteen volunteers in the same geographic area come together to form a care group which meets every two weeks to exchange ideas, receive peer support and training from paid WR promoters. Each promoter provides training and supervision to 8 -12 (with the exception of one promoter who supervises 17 CGs, although this is under review) care groups depending on geographic area and distance between care groups and households. Promoters in turn are trained and supervised by project supervisors; twice a year they are trained intensively in training camps with review and joint problem solving taking place at monthly meetings. Promoter and volunteer training materials are developed according to standard IMCI protocols endorsed by the MOH.

The effectiveness of the CG model for community based initiatives has been disseminated in scientific forums of APHA, GHC, CORE and documented publications with CORE. The model has also been adopted by other WR CSP in Mozambique Cambodia and Rwanda; Food for the Hungry in Mozambique, and Curamericas in Guatemala, among others. The model facilitates dialogue between the health system and the community, empowers communities by enabling them take the lead in assessing their health needs, and developing appropriate strategies to bring about lasting change.

Program objectives and conformance with USAID Mission and Malawi MOH Health Plan/Policy

Specific program objectives include 1) **strengthening the capacity of Chitipa District's health system** to implement Child Survival and Health interventions according to IMCI protocols. This will be achieved through staff training and supervision, and establishing an effective health information system aimed at improving the quality and coverage of C-IMCI services, 2) **developing sustainable community-based mechanisms** to improve prevention and care-seeking practices for childhood illnesses at household and community level, and 3) **improving coverage and utilization rates of malaria control strategies** according to Roll Back Malaria guidelines.

The strategic framework of the program conforms to the Malawi MOH National Health Plan 2004 - 2009 and USAID Mission's Strategic Plan 2001 – 2005, focused primarily on promoting improved health behaviors and services relating to maternal and child health at community and health facility level. Table 5 illustrates how CSP strategies and interventions conform to MOH and USAID Mission strategies.

Table 5: MOH, USAID, & CSP Program Priorities

MOH Program of Work (2004/05-2009/10)	USAID Malawi Strategic Plan (2001-2005)	WR CSP (2006-2009)
Reduce disease burden due to communicable and non-communicable diseases through improving access to a quality Essential Health Package (EHP), essential non-EHP services and Emergency and Trauma services mainly targeted at the poor.	IR8.2 Quality of services improved: Knowledge of good health/nutrition practices and own HIV status improved During FY 2003 the Mission launched three new "lead" implementing instruments which are expected to i) reduce child morbidity and strengthen health care systems ; ii) increase the availability and improve the quality of HIV/AIDS related support services; and iii) reduce the risk of contracting HIV through behavior change and communications.	Support implementation of C-IMCI interventions of diarrhea, malaria, ARI, nutrition and immunizable diseases. Promote awareness about HIV/AIDS prevention.
Strengthen the role of communities in decision-making on health issues.	IR8.3 Access to services improved: Community participation in health care, including orphans' care, increased in target communities	Create extensive community based mechanisms for improved preventive and care seeking behavior for maternal and child health. Empower CG and VHC to identify and address problems and create effective links with the health system.
Increase the capacity of the health sector to train, recruit and retain the necessary quantity and quality of health human resources. Increase the capacity of the decentralized District Health System to plan, budget and deliver quality health services.	IR8.4 Health sector capacity strengthened: Range and quality of health services for mothers and children under five expanded in target districts.	Improve health system capacity: training, supervision, Monitoring and Evaluation skills, drug management and supply.

Program Objectives

1) Strengthen the capacity of Chitipa District's health system to improve the quality and Coverage of IMCI services

Malawi's health system is managed at central, regional and district levels. At the district level facilities are organized into District Hospitals (DH), Health Centers (HC), and Health Posts (HP). The ongoing decentralization process brings decision making closer to the community and health service users in rural areas. The District Assembly, through the District Executive Council designs, plans and implements health programs at the district level, with human and financial resources provided from the central MOH. Chronic shortage of skilled personnel at all levels of the health care system (worse in rural areas) coupled with scarce financial resources limit the capacity of the health system to meet the needs of the population.

The health system in Chitipa District includes a District Hospital, managed by the District Health Officer (DHO), 8 Health Centers (HC), 33 Health Posts (HP), and 45 outreach clinics. The DHO leads the District Health Management Team (DHMT) which provides technical support to HCs and HPs especially concerning disease surveillance, M&E, and cold chain back up. The District Hospital functions as a referral center, with laboratory and surgery facilities, in-patient and out-patient facilities, while the HCs serve as secondary level facilities. HCs provide in-patient and out-patient services, with staff skilled to administer intravenous medications, conduct ANC and normal deliveries, run immunization clinics and outreach services; and FP services. Each HC serves an average population of 10,000 people. HPs, managed by HSAs, provide the first level of health care services to the community, including provision of oral medications such as SP, paracetamol, iron supplements, deworming tablets; wound care, patient education and counseling, and immunization services (both facility-based and outreach services).

Health Surveillance Assistants (HSAs) also maintain village registers through which vital data are collected from the community. Several community-based health service providers exist in Chitipa District, including community-based distribution agents (CBDA) who provide door-to-door FP services, social welfare Assistants (SWA) who coordinate community-based organizations and community-based child care centers funded by UNICEF, Growth Monitoring (GM) volunteers who mobilize mothers to access GM services, Drug Revolving Fund (DRF) volunteers and ITN committees.

Chitipa's non-formal health sector service providers include traditional healers (herbalists), witch doctors (spiritists), pastors (especially Zionist pastors who forbid the use of medications for ailments), drug sellers, TBAs, and indigenous FP practitioners. Because these providers are readily accessible and affordable, they remain a popular choice for primary care among the general population, especially for illnesses believed to have spiritual origin, such as pneumonia, convulsions, and difficult deliveries. Traditional healers typically administer treatment for three days after which they decide to refer to HF if there's no improvement.

To achieve the objective of health system strengthening, the project will focus primarily on building the capacity of HC and HP staff in IMCI service delivery. Staff will receive training in standard case management protocols, essential drug supply monitoring, establishing effective surveillance systems, and promoting improved access to health services. Health facility staff will also receive training in non-technical areas including basic problem solving approaches, supportive supervision, maintenance of good referral systems, joint activity planning, and staff management.

District MOH staff will be trained alongside project staff in Health Facility Assessment (HFA) methodology using appropriate tools and guidelines. These guidelines and instruments will be integrated into the MOH M&E system for ongoing monitoring of quality of care provided at health facilities. The program plans to conduct two HFAs, scheduled for years one (July 2006) and four. HFAs will assess program and provider performance using case management observations, exit interviews, health provider interviews and record reviews to examine compliance to case management protocols, knowledge of providers, effectiveness of caretaker counseling; drug supply and management. Baseline HFA results will be reviewed with MOH staff with the aim of developing strategies to fill any gaps identified by the assessment.

Specific Intermediate Results have been developed to measure progress towards achieving the objective of health system strengthening. See Table 6 below:

Table 6: Indicators for Strengthening Health System Capacity for IMCI Implementation

<i>IR</i>	<i>Indicators</i>	<i>Measurement</i>	<i>Activities</i>
Improved knowledge of providers	% of providers who have IMCI/C-IMCI training	LRA, HFA	Training and supportive supervision of HSAs and HC staff
	% of HSAs and HC staff who comply with standard case management protocols	Supervision of HSAs conducted jointly by CSP and MOH staff	Joint M&E planning and implementation with MOH
Improved access to preventive health services	% of target population with access to preventive health services (<5km)	KPC, LRA	Support outreach activities HSA training and supervision by CSP and MOH staff
Community Health Information System(CHIS) Monitoring ring	% of HSAs who provide monthly CHIS data to HC	Monthly statistics and CG HP records	Review existing CHIS Train and support VHCs to monitor HSAs and CG volunteers, and interpret HIS results

In conjunction with the District Environmental Health Officer (DEHO) the existing HSA training curriculum will be reviewed to ensure consistency with IMCI protocols. Joint training sessions for HSAs and promoters will be designed and conducted by MOH and CSP

staff, with the ultimate goal of training HSAs to fill the role of promoters from the second half of the project. Senior HSAs will work closely with project supervisors to standardize training objectives and content, and develop effective supervision checklists. The project will work with the District MCH coordinator to design an effective and sustainable supervision plan for HSAs, one that can be managed by MOH staff after the program has phased out. HSAs will be equipped with the same training materials as promoters and volunteers to ensure uniformity of information disseminated at community and household level. SWAs teach CBO volunteers and committee members about the 17 key family care practices according to IMCI protocol in Malawi, and the project will seek opportunities for collaboration with this group for reinforcement of consistent messaging. Since CBDAs have continued to provide FP services in the community with support from the MOH, the project will promote cross-learning and sharing of experience on program implementation and sustainability strategies. Through the HSAs, Drug Revolving Fund volunteers will receive refresher training and improved supervision to ensure optimal case management practices according to IMCI protocols, and for quality assurance monitoring. The program will also explore mechanisms to provide training to drug sellers, traditional healers, and community leaders by involving them in program information dissemination meetings and providing updates on best practices for program interventions. Care groups for religious leaders will also be formed, receiving training from promoters in the training curriculum used with standard care groups of volunteers.

TBA training by the government has been halted as the role of TBAs in health care delivery is being reviewed. Until clear guidelines about TBA training are released the project will promote prompt HF referral. However, in communities that have limited or no access to delivery at HF, the program will continue to advocate with government to review the training policy especially for communities with very limited access to HFs.

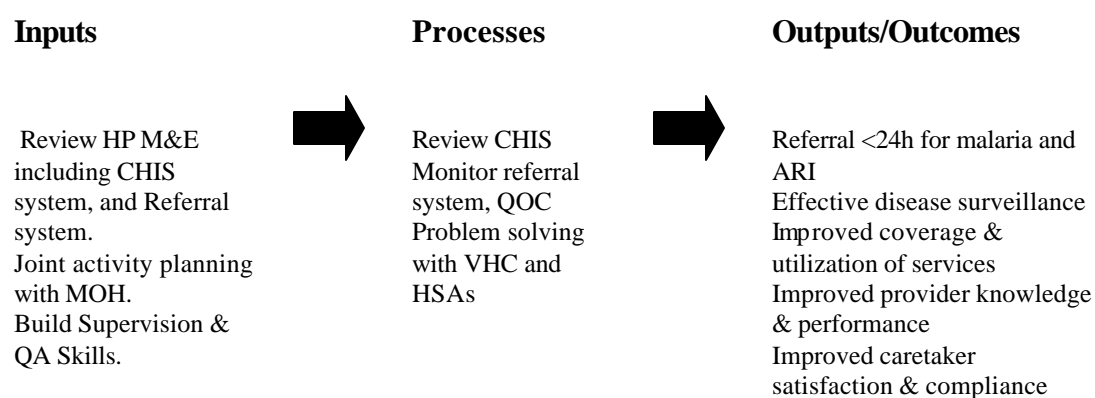
Monitoring of CHIS: Project CHIS will be integrated into the district health information system to facilitate appropriate disease surveillance and timely decision making by district MOH and CSP staff at community and facility levels. Those indicators that are common to the project and the MOH will be integrated into the existing MOH HIS, with CGs providing household level information which is not collected by HSAs in the current system. The Project will share CHIS information with the MOH during monthly meetings, on relevant indicators that are specific to the CSP, to promote evidence based decision making and timely interventions. Discussions about the best method of integrating both systems are ongoing between the MOH District Statistician and CSP program Director continue to discuss the best strategy to employ in ensuring a meaningful integration takes place. CG volunteers will be part of community based data source groups who collect data and report to HSAs.

Quality of IMCI Services: CSP Program Director and Deputy Director will participate in monthly strategic planning and dissemination meetings organized by the District Planning Secretariat to review data on quality of care, service utilization, drug supply and management, and to develop initiatives for improving quality of IMCI services. Quality Assurance training will be conducted for HF staff to build their capacity in applying quality management methods to diagnosing, measuring and improving gaps in performance. Efforts

will be made to ensure that initiatives developed are in line with existing National MOH IMCI guidelines. TPCSP project director is a member of the national IMCI working group, a forum for providing useful feedback that would influence national and district IMCI policy. The program will facilitate the formation of a similar district based C-IMCI advisory technical team comprising MOH technical staff and staff from social institutions such as the MGCWCS, to provide technical support and direction for IMCI implementation.

Health facility level IMCI system will be appraised and indicators for inputs, processes and outputs measured and monitored according to Figure A below.

Figure A: Monitoring Indicators in the IMCI System



2) Develop sustainable community-based mechanisms to improve prevention and care-seeking practices for childhood illnesses at household and community level

The Care Group model for training and sustaining community health volunteers will be used for implementing C-IMCI in Chitipa District, building on its success in the previous CSP in Mzimba and Rumphi Districts of Northern Malawi. Due to its success in the previous projects, considerable interest was generated in the model as a viable approach for institutionalizing C-IMCI in the PHC community, and Chitipa DHMT invited WR to implement this in Chitipa.

108 Care groups were established in Embangweni, Mzimba District in 2001, and almost two years after the program ended (EOP 2004), these CGs have continued to function as agents of change in their communities, and continued regular meetings to discuss health issues. These CGs have continued to receive strong support from village headmen, technical support and supervision from Embangweni Hospital PHC team; and they receive motivation from the reduction in mortality and morbidity rates in their communities. In addition, the WR Malawi CSP team also monitors CG activities quarterly. A site visit to the former CSP site was conducted by CSP staff in December 2005 to introduce the PD/Hearth strategy to an NGO consortium in Malawi led by Africare, with partners Catholic Relief Services, Save the Children, World Vision, Care International, Emmanuel International and Salvation Army, at

their request. This group is exploring mechanisms of adapting the CG approach for PD/Hearth implementation in Central and Southern Malawi.

Description of Care Group Structure: One volunteer assumes responsibility for 10- 15 households in his/her immediate neighborhood depending on population density of area covered. Ten to fifteen of these volunteers aggregate into “Care Groups” which are facilitated by promoters. Every volunteer promotes behavior change communication (BCC) and teaches key household practices related to the causes of common illnesses, appropriate prevention and prompt care-seeking practices (relating to program interventions) through culturally appropriate messages and media. CG volunteers will be mentored by local project staff and trained by health personnel skilled in C-IMCI using a cascade approach and standard protocols endorsed by the MOH. CGs meet fortnightly to receive training and supportive supervision from the promoter in addition to program review and planning, and CHIS data compilation and review. Promoters are trained and supervised by supervisors who receive training and supervision from the program director and his deputy.

The CG strategy is based on an extensive network of volunteers (3060 for the project area) trained to provide universal coverage of services to all households. The CSP will integrate the CG networks within existing institutions, including Village Health Committees (VHC), HSAs, pastors, traditional healers, and drugs sellers, and the health district, creating a sustainable support structure for the volunteers and further building capacity of communities and the health system.

Community Support Systems: The project will build strong support for the CG system by mobilizing existing community-based groups to work with them. Areas of overlap and synergy with existing community-based organizations will be identified and collaboration will be promoted. Community meetings are an ideal platform for introducing new interventions, resolving issues, discussing M&E results as a tool for evidence-based decision making. Village headmen and VHC chairmen will be engaged actively in program design, planning and implementation through the life of the project. They will receive verbal/written reports of CHIS data and will receive public acknowledgement of their contribution when the project demonstrates success. **Village Health Committees, Pastors’ and Traditional Healers’ Care Groups** will receive non-formal training adapting the same training materials used for volunteers. These joint meetings and trainings will provide an opportunity to build new relationships and strengthen existing ones while promoting accountability within the community. VHC members, HSAs, Church leaders, traditional leaders, and other community-based groups will receive leadership and skill building training to prepare them to supervise and provide support and motivation to CGs and provide the necessary linkage to the MOH and District policy makers.

Health Surveillance Assistants (HSA): HSAs are community health workers employed by the MOH to provide primary level preventive and curative health services at health posts. Services provided include treatment of uncomplicated malaria, diarrhea disease control, including ORS, conjunctivitis, and growth monitoring services. HSAs provide immunization services at HPs on specific days of the week and outreach services every month. There is one HSA per 2000 population, with a total of 92 HSAs functioning in Chitipa. HSAs are O’level graduates who receive eight weeks of initial training before assuming responsibility for HPs.

Some HSAs have specialized roles such for VCT services, cold chain supervision, skin disease control, border health, and nutrition rehabilitation. Many communities are not reached by HSAs, especially those without HPs. In addition to health care delivery services provided, HSAs work with communities to identify, prioritize and develop strategies to solve community health problems, and provide BCC on disease prevention to communities. They provide technical support to VHCs and DRF volunteers. HSAs have standard reporting forms for collecting demographic data and vital data, which are reported to senior HSAs and HC in-charges where there are no senior HSAs. The data are then collated and sent to the DEHO and eventually the district statistician who enters them into the district health information database. The CSP program plans to integrate the project's HIS system into the MOH HIS to ensure household level data is available to decision makers, and to promote sustainability. HSAs will work closely with CSP promoters and CGs to ensure consistency in health messages disseminated at household and community level, using the care groups to extend the reach of the HSAs.

The project will support and strengthen HSAs in their supervisory role of Drug Revolving Fund Volunteers (see below). The project will assist with logistical challenges within the means of the project and assist the MOH with improving the existing drug distribution, management and monitoring system.

Village Health Committees (VHC): Village Health Committees, also known as the 'village parliament', exist in most communities in Chitipa to provide supervision to community health volunteers, and provide community health information to HSAs. VHCs also plan and initiate local projects such as construction of GMC shelters, maintenance of shallow well sites, and promotion of sanitation initiatives. They conduct village health inspections and mobilize households to participate in immunization campaigns, child health days and other outreach activities. VHCs are active in 421 of 475 villages in Chitipa, and they hold monthly meetings where activity planning, updates and program review occurs, and local health-related policies are made. In Chitipa, VHCs typically comprise ten members (six men and four women) selected by the community to serve as the link between the community and MOH, and advocate for improved community health services. The VHC team leader provides oversight and coordination, while the remaining nine members fill specialized roles like DRF volunteer, ITN committee volunteer, and sanitation committee volunteer. The national health system has recognized VHCs as an integral part of the community's health system, but due to lack of adequate support and training, their contributions have been minimal. VHCs report to village headmen and receive technical support from HSAs. Because village leader support is a powerful influence in the community, the project will work closely with village leaders, through VHCs, to raise awareness about disease prevention and control at household and community level.

VHCs will be encouraged to support CGs, and sensitized to the plan to have VHCs supervise CGs on the long run, when the program would have phased out. The project will therefore build the capacity of VHC members in supportive supervision, and use of community level data as a tool for advocacy.

Church leaders: Church leaders hold a very important position in communicating behavior change messages in any community, and especially in Chitipa where 98% of the population

is Christian. Church leaders exert great influence on beliefs and practices, and are often consulted and called to pray for congregation members and their families when they are sick. Church leaders will receive training from promoters during monthly meetings. Pastors will be encouraged to communicate these messages to their congregations at large and during individual counseling opportunities, thereby reinforcing BCC messages shared by volunteers. Pastors' leadership is particularly important in confronting the stigmatization associated with HIV/AIDS and orphan care and support.

Traditional healers and community drug sellers are readily accessible to community members, and often sought after even though some of their practices and prescriptions are harmful. This group will be targeted for training in project interventions, with emphasis on referral guidelines for children and pregnant women with common illnesses such as malaria, diarrhea, pneumonia, and vaccine preventable diseases. Information will be presented in a non-judgmental manner, with training materials designed to promote healthy discussion and dialogue about causes of illness and current practices.

Drug Revolving Fund (DRF) volunteers are community-based volunteers who provide first line treatment for common childhood illnesses including uncomplicated malaria, ORS for diarrhea, and wound care for a fee (the government does not yet allow community case management of pneumonia, although this policy is under review). Drug kits are provided by UNICEF through the MOH system, and replenished from money generated from sales. There's typically one DRF volunteer per village, and many DRF volunteers come together to form DRF committees where community health issues are discussed. They are supervised directly by HSAs, but have been non-functional in most parts of Chitipa because of problems with drug supply, supervision and accountability.

The project will coordinate with DRF volunteers as vital sources of first line treatment for common illnesses including malaria and lobby for their support and revitalization where not presently functioning. The project will advocate with the government to allow community management of pneumonia by DRF volunteers as well.

Other community programs: In addition to working with existing community groups, the project will collaborate WV Malawi, CADECOM, Ministry of Gender, Child Welfare and Community Services and partner churches led by CCAP SOL, to promote behavior change at community and household level. WR will facilitate cross learning between partner organizations through its participation in District Secretariat and other district policy meetings.

Table 7: Illustrating collaboration strategies between CG and main community players

Community group	Main roles and functions	Strategies for collaborating with CG
Village Health Committee	Community health volunteer supervision, provision of community health information to HSAs, local project planning and implementation, community inspections, and community mobilization.	Create link with CGS through participation in monthly meetings, capacity building in supportive supervision and use of community level data as a tool for advocacy.
Health Surveillance Assistants	Provision of primary level preventive and curative health services; and data collection and reporting.	Joint training with promoters on technical interventions and supportive supervision of CGs and other community volunteers.
Pastors	Great influence on people's beliefs and practices.	Training on program interventions, and supportive supervision of CGs
Traditional Healers	Provision of curative services at community level.	Training on program interventions, with emphasis on prompt patient referral.
Drug Revolving Fund	Provide community-based case management of uncomplicated malaria, and first line management of common childhood illnesses except ARI.	Strengthen existing DRFs by providing training in project interventions, drug distribution, and quality assurance strategies.
Social Welfare Assistants	Coordinate and supervise CBOs and CBCCs	Regular meetings with CGs and project will build the capacity of SWAs in data management

3) Promotion of Key Family Practices for Child Health

Care Groups: The vehicle for transformation is a vast network of 3060 community volunteers, trained and mentored by 32 health promoters in “care groups”, each comprised of 10 -15 volunteers. Each volunteer shares what she learns during CG meetings with 10-15 neighboring households so that each family in the district with U5 children and WRA receives BCC messages, social support and encouragement in their own homes every two weeks. All family members, including fathers and grandmothers, are invited to participate in visits from their volunteer. Training numerous volunteers in each village provides a critical mass for community-wide change and the maintenance of changed behaviors. CGs are effective in this communities because they reflect communal values, provide encouragement and social support to volunteers, and permit the development of highly effective traditional educational methodologies such as song and drama.

CG volunteers were selected through the collaborative efforts of church and community leaders, using set criteria developed by the CSP team and stakeholders. Some of the selection criteria included trustworthiness, non-addiction to alcohol, willingness to work voluntarily without pay, previous experience as volunteer, willingness to walk long distances if required, and age 35 to 50 years, irrespective of gender (though females were preferred from experience in previous CSP and FE recommendations) or denominational affiliation.

In addition to training in prevention, care seeking and home management of childhood illness, volunteers will report vital events for their 10-15 households during bi-monthly meetings. The CGs will discuss the CHIS reports, focusing on problems that emerge within individual households as well as the community at large. The aggregated findings will be presented to VHC, HF staff and the DHMT. The CHIS is just one part of the program's monitoring system, as discussed in Section E4. Involvement of the community in information gathering and reporting will create a forum for building problem-solving skills and promoting community dialogue.

Promoters play a key role in the CG structure, serving as Trainer-of-Trainers for diverse CGs, including Pastors' CGs, traditional healers' CGs, working with VHCs and HSAs and other community-based organizations. Each promoter trains and supervises 8-12 CGs (with the exception of one promoter who supervises 17 CGs, and this is being reviewed) during regular meetings. They also maintain the CHIS data collected by CG volunteers. The district Health Surveillance Assistants will work closely with project promoters, receiving joint training and building skills to supervise CGs in the absence of promoters. CGs will provide CHIS data collected at household level to HSAs who will pass this on to HC staff and eventually to the district statistician. Early in the project, CGs would be incorporated directly into the health system chain, thereby creating a sustained link between the MOH and the CG system.

Behavior Change Interventions: Multiple methods and channels of reinforcement will be used for behavior change communication. During the course of the project, volunteers, pastors, traditional healers, MOH staff, and VHC members will be trained to deliver the same essential messages consistent with IMCI protocols. Communities will receive messages through multiple delivery systems: at home, church, village meetings, celebrations, etc. A variety of communication methods will be used to reach care givers with the most essential messages through songs, drama, role play, dances, clinic encounters, and sermons in addition to the project's pictorial curriculum. Pictures and other appropriate visual aids have been found to be effective in reaching illiterate volunteers and caretakers. This will be used extensively in this program because of high levels of illiteracy among CG volunteers and household members. The pictures will highlight one main theme/topic, with a central main picture, and smaller peripheral ones relating to the main topic used to guide the discussion. Existing BCC materials will be revised and adapted in the new project.

Training: The prior CSP's training curriculum will be updated and reviewed according to the most current MOH protocols for use by volunteer, pastor and traditional healer care groups. Training materials will be developed to give key messages which incorporate FGD and other baseline assessment findings, using simple messages and pictorial illustrations.

Training on project interventions will be phased in one after the other using a cascade approach. All project interventions will be covered in the first two years, and refresher training will be conducted in the second half of the project. Promoters, HSAs, and select MOH staff will come together in ‘training camps’ for a week to receive intervention specific training as each intervention is phased in. Promoters will train volunteers in key messages for disease prevention and appropriate care seeking practices using culturally appropriate methods during care group meetings. Volunteers will be evaluated orally, to assess their level of knowledge of each intervention after every intervention approximately three to four months. Each volunteer will reach his/her respective households during home visits with the same key messages for about an hour at least once every two weeks. Please refer to Training Plan in Section E6.

Quality of Care: Quality assurance tools such as standard supervision and monitoring checklists will be developed for ongoing monitoring of the quality of health messages given at household level, level of knowledge of CG volunteers, CG and VHC training and supervision, and aggregation of CHIS.

Access to appropriate services through training of HSAs, CBDAs, SWAs, drug sellers: Access to health facilities continues to be a major deterrent to appropriate care-seeking practices for many communities in Chitipa mainly because of distance. However, a significant proportion of people who live within 5km of a HF still do not access HF services because of long waiting periods, HF staff attitude, and cultural beliefs about etiology of illnesses. The project will provide training to existing health service providers (formal and non-formal sector) in the community to improve utilization of existing appropriate health care and services.

Program Interventions

The program will focus on the following C-IMCI interventions – malaria control, pneumonia case management, diarrhea disease control, nutrition, child immunization and HIV/AIDS prevention. Program interventions were discussed in detail with MOH personnel, and they reflect Chitipa District MOH priorities. Summary tables of objectives and indicators are in Section E4 on Monitoring and Evaluation.

Malaria Control

Program Objectives: 1) 50% of children with fever (suspected *malaria*) receive treatment by trained provider within 24h of onset of symptoms
2) 60% of children sleep under ITN

Malaria is endemic in Malawi, accounting for the highest number of hospital visits across all age groups in Malawi with children under five and pregnant women being most vulnerable. Malaria is the leading cause of U5 morbidity and mortality in the country, causing 40% of all U5 hospitalization and 40% of U5 hospital deaths. Thirty- seven percent of all recorded deaths in Chitipa were attributed to cerebral malaria in 2000-2001^{LXXXVII}. The most recent

^{LXXXVII} Chitipa District Socio Economic Profile. Republic of Malawi October 2002.

MOH surveillance data for under-fives reported 86.2 cases of malaria/1000 population during the 3 month period. It is known that over 50% of malaria cases in Malawi do not receive treatment at HFs^{LXXXVIII}.

Malaria control - Nationwide, only 42% of households have at least one **bed net** (only 27% have ITNs) for and average of 0.7 nets per household^{LXXXIX}. Only 27% of U5s and 20% of WRA slept under a bed net the night prior to the DHS survey. In the Northern region, 47% of households possess at least one bed net; 32% of U5s and 23% of WRA slept under a bed net the night preceding the DHS survey^{XC}. Findings from baseline studies conducted in Chitipa regarding caregiver knowledge indicate that a good proportion understand that mosquitoes bring malaria at night, but quite a number do not understand the link between bed nets and malaria^{XCI}, and beliefs linger regarding transmission to humans from evil spirits, bad water and unhygienic practices.

Access to treatment and care-seeking for malaria is poor. Baseline KPC findings report that only 17.5% of children 0-23m with fever in the two weeks preceding the survey received treatment at a HF within 24h of onset of the fever. In addition 82.5% of mothers would seek treatment for symptoms of malaria *after* 24hours of onset of symptoms, whereas WHO recommends treatment *within* 24 hours. Reasons for this delay include distance from the health center, belief that malaria is caused by evil spirits, and the long waiting periods at HFs. Although treatment in public health facilities in Malawi is free, long waiting times and poor attitudes of HF staff constitute barriers to health service utilization. Only one in five U5 children and pregnant women have access to prompt and appropriate treatment and about one-third of pregnant women receive IPT.^{XCII}

Over 85% of malaria infections are due to *Plasmodium falciparum*, but resistance to anti-malarial drugs has posed a major threat to malaria treatment in Malawi. Though Malawi adopted SP as the first line treatment of malaria in 1993, resistance to SP has increased to 25-31% by 2004 (report from 6 sentinel sites)^{XCIII}. Latest results report a 41% resistance to SP^{XCIV}, but the national MOH has not adopted Artemisinin Combined Therapy (ACT). Though the MOH has been planning to change to ACT, concerns about cost and therefore affordability and accessibility remain a major challenge. However, SP remains the first line anti-malarial for uncomplicated malaria, while quinine is used for severe and resistant cases. The program will work with the MOH as it seeks to adopt a new malarial treatment policy. The national MOH assumes primary responsibility for disseminating information on health policy changes, but the project will collaborate with the district MOH to ensure that the information reaches the community-level should the malaria treatment policy change.

Malaria control has been integrated into the general disease programs, under the new decentralized system, with the DHO serving as the overall officer in charge of district health

^{LXXXVIII} Malawi National Malaria Control Program Strategic Plan 2005-2009

^{LXXXIX} Malawi DHS 2004

^{XC} Malawi Preliminary DHS 2004

^{XCI} Child Survival Program Focus Group Report, 2006

^{XCII} Global fund for AIDS, TB and Malaria

^{XCIII} Malawi National Malaria Strategic Plan 2005-2010

^{XCIV} verbal report, National Coordinator, IMCI dept

program planning and implementation. The National Malaria Control Program advocates community based strategies for prompt and correct treatment seeking practices, social marketing strategies for improved access and affordability of ITN, behavior change communication to stimulate demand and to ensure correct use of ITN.

DRF volunteers provide community case management of malaria using SP as first line therapy, and the project will build the capacity of this group of providers to ensure continuous availability of antimalarials at community level.

Based on the heavy burden of malaria in Chitipa and results of baseline assessments, the project has prioritized malaria control and prevention at community and household levels, while promoting prompt care seeking and optimal care provision by health care providers.

Mothers/caregivers will receive messages during home visits on home management of fever, complications of malaria and danger signs (i.e. child looks unwell, is not eating or drinking, lethargy or change in consciousness, convulsions, vomiting everything, high fever, fast or difficult breathing) that warrant immediate treatment at a HF. The importance of seeking care from appropriate health care provider within 24 hours of onset of symptoms will be emphasized to mothers and caregivers. Children with suspected malaria who receive treatment at HP/HC will be followed up at home by CG volunteers to monitor compliance to therapy and identify early signs of non-response or need for referral. In addition to messages targeting under-fives, pregnant women will be encouraged to register early for ANC, take two doses of SP and iron supplements (for at least 60 days) in pregnancy. Emphasis will be laid on the adverse effect of malaria in pregnancy, including anemia, delivery complications, low birth weight and increased risk of mortality to both mother and child.

Currently, ITNs are socially marketed at health facilities and through ITN committees, and provided at subsidized rates to pregnant women and children under-five, ensuring that most women and households in the district can afford them. The NMCP plans to provide ITNs for free to the poorest of the poor households, using select criteria. CG volunteers will promote awareness on the impact of ITN utilization on malaria morbidity and mortality, and encourage ITN utilization all year round. CGs will work closely with ITN committees, VHCs, and other community-based groups to ensure that ITN purchase and utilization is adequately promoted. ITN re-treatment will also be promoted until long-lasting ITNs are readily available in the country.

Pneumonia Case Management

Program Objective: 50% of children with rapid, difficult breathing (suspected pneumonia) treated at HF within 24h of onset of symptoms

Pneumonia contributes to the high burden of under-five morbidity and mortality in Chitipa; second only to malaria. The picture is worsened by the common belief that pneumonia is caused by witchcraft and therefore care sought from traditional healers rather than HFs. There are 1.26 million reported episodes of pneumonia in under-fives annually, constituting 12% of all U5 illnesses in Malawi. Nationwide, ARI accounts for 23% of in-patient deaths

^{XCIV} and only 18% of children with ARI receive treatment at a HF^{XCIX}. Access to care is limited by the same factors that impede care for malaria and other common childhood illnesses. Oral cotrimoxazole is the drug of choice for treating pneumonia in under fives in Malawi. Cotrimoxazole tablets are readily available to mothers from HFs, HSAs, drug vendors and other private providers, but the MOH does not authorize dispensing antibiotics at community level. HSAs evaluate and provide the first dose of cotrimoxazole to children with suspected pneumonia, and then refer to the nearest HF.

The National MOH Policy on ARI management is undergoing review; the new policy will likely include Health Surveillance Assistant (HSA) training to manage ARI at health posts and in the community. Discussions with the C-IMCI National Coordinator revealed support for districts (and NGOs) with the capacity to initiate community case management of pneumonia, realizing the importance of engaging HSAs and Drug Revolving Fund volunteers (who are at the community-level) in integrated case management of diarrhea, malaria and pneumonia.

Drug supplies have already been delivered to ten districts in Malawi. The drugs will be sourced from the Central Medical Stores as part of Essential Health Package (EHP) to the Health Center. A community representative would accompany an HSA to collect drugs for the HP from the HC, and for accountability and transparency purposes both the HSA and community representative will keep records and countercheck with each other every time drugs are re-stocked. The project will continue discussions with the MOH at national and district levels to ensure that clear guidelines are developed for the CCM of pneumonia initiative.

Specifically related to Pneumonia Case Management, the project will create awareness about the etiology of pneumonia and measures to prevent and treat pneumonia, using culturally appropriate BCC methods. Mothers and caregivers will learn that pneumonia is not only treatable when diagnosed early, but it is preventable. Emphasis will be on early recognition of pneumonia symptoms - fever, cough with fast and rapid breathing; and recognition of danger signs (difficult breathing, child looks unwell, is not eating or drinking, lethargy or change in consciousness, vomiting, high fever), that warrant immediate HF treatment. Children who receive treatment at HP/HC will be followed up at home by CG volunteers to identify early signs of non-response or need for referral. In addition, mothers and caretakers will learn that good nutrition including breastfeeding and vitamin A supplementation, and complete immunization reduces the incidence of severe pneumonia and the risk of pneumonia-related mortality. Pastors and traditional healers will also receive training on the prevention and control of pneumonia so as to assist in prompt referral to HF. The project will strengthen the existing referral system to promote access to prompt and appropriate care, while promoting quality care provision at HF. Health facility staff will receive training on optimal pneumonia case management according to IMCI protocols.

^{XCIV} National Statistics Office [Malawi] and ORC Macro. 2001. Malawi Demographic and Health Survey 2000.

Zomba, Malawi and Calverton, Maryland, USA: National Statistics Office and ORC Macro

^{XCVI} Malawi Preliminary DHS 2004

Overall, mothers and caretakers will learn to 1) recognize symptoms and danger signs of pneumonia 2) seek prompt treatment from a trained health provider within 24h 3) comply with treatment instructions and continue or increase food and fluids given to children following episode of pneumonia, including continued breastfeeding, and 4) receive vitamin A supplements for children aged 6months to 5years every six months.

Control of Diarrheal Disease

Program Objectives:

- 1) 75% of caretakers know at least 2 danger signs^{XCVIII} for seeking care immediately
- 2) 60% of *sick children* offered increased fluids and food during illness
- 3) 60% of caretakers wash hands before food preparation, before child feeding, after defecation and after cleaning child's feces
- 4) 60% of children with diarrhea receive ORT

Diarrhea diseases continue to be a public health concern in Chitipa primarily because of harmful practices during diarrheal episode and a general lack of knowledge about prevention and prompt care seeking practices to prevent diarrheal disease complications, dehydration and malnutrition. Children suffer an average of five diarrheal episodes per year^{CI}. Two week prevalence for diarrhea was reported to be 18% in U5 children and 36% in infants 6-11^{CII} months in 2000. Diarrhea is seasonal, peaking from December to April and lowest during July and August^{CIII}. Preliminary results of the 2004 DHS survey report that 61% of children with diarrhea in the 2weeks prior to the survey received an ORS packet, 70% received ORT, and 33% were taken to a HF for treatment^{CIV}. FGD findings reveal that diarrhea is a common child health problem in most communities in Chitipa. In Chitipa District, 78% of the population has to travel over 20 minutes to a safe water source, with worse rates in Wenya and Mwaulambia areas of Chitipa^{CV}. Over 70% of households in the district have access to a latrine, but improper disposal of waste continues to be a major challenge to sanitation in the district.^{CVI} Soap is readily available in most communities (alternatives like ash will be promoted in its absence).

^{CI} Malawi Health Management Information Bulletin. Special Issue 2002. Ministry of Health and Population Planning Department, Health Management Information Unit. June 2003

^{CII} National Statistics Office [Malawi] and ORC Macro. 2001. Malawi Demographic and Health Survey 2000 Zomba, Malawi and Calverton, Maryland, USA: National Statistics Office and ORC Macro.

^{CIII} Malawi Health Management Information Bulletin. Special Issue 2002. Ministry of Health and Population Planning Department, Health Management Information Unit. June 2003

^{CIV} Malawi Preliminary DHS 2004

^{CV} Chitipia District Socio Economic Profile. Republic Of Malawi October 2002

^{CVI} Chitipia District Socio Economic Profile. Republic Of Malawi October 2002

The Malawi National MOH has not authorized the use of zinc in diarrhea, and it is not yet included on the National Drug List. However, the Ministry of Health is currently updating Malawi Standard Treatment Guidelines (MSTG) and the Pharmacists with Central Medical Stores are being encouraged by the IMCI department to include zinc on the drug list. The project will continue to advocate with MOH IMCI Program for both the inclusion of zinc on the drug list and that, ultimately, zinc be made available at the community level.

Diarrhea prevention messages will focus on stopping transmission of pathogens through oral-fecal contamination and will include: 1) promotion of basic hygiene practices (safe disposal of stools including use of latrines, washing hands before food preparation, before feeding child, after defecation and after cleaning child's feces; use of dish racks, protection of household water sources [i.e. cover water pots with clean materials, set aside specific drawing cups, and promotion of year round pot chlorination using chlorination materials made available by the MOH]), 2) promotion of exclusive breastfeeding for the first six months of life and introduction of appropriate complementary feeding from six months. Once zinc has been approved and becomes widely available in Chitipa, the project will raise awareness of its importance and will incorporate zinc into BCC messages.

Case Management Strategies for acute diarrhea and dehydration will be 1) to promote appropriate dietary management during diarrhea by continuing breast feeding, giving small frequent feeds to children 6 months and older, offering same or increased fluid and food intake during and up to 2 weeks following diarrhea episode, 2) promote use of ORT (including home-based fluids such as maize water, rice water, herbal tea) to prevent dehydration and nutritional deprivation due to diarrhea disease, 3) recognize danger signs requiring prompt referral to HF (i.e. blood in stool, persistent diarrhea - >14 days, sunken eyes, loss of skin turgor, fever, etc); 4) discourage antibiotics or anti-diarrheal use unless prescribed at the HF by a trained provider.

Children with diarrhea will be followed up at home by CG volunteers to monitor response to therapy and encourage optimal feeding practices. ORS supplies at HF will be monitored, and volunteers serving areas where there are no HSAs will be trained to encourage caretakers to prepare and administer home available fluids. Prompt referral to appropriate HFs will be promoted by CG volunteers trained to recognize danger signs of diarrhea disease.

Immunization

Program Objective: 80% of children 12-23m fully immunized by their first birthday.

Malawi has experienced a steady decline in immunization coverage rates over the last two decades, with rates of 64% for children 12-23 months with full immunization status, compared with 82% and 70% in 1992 and 2000 respectively^{CVI}. This is true for all types of vaccines. Baseline KPC findings revealed a measles vaccination coverage rate of 55% for children 12-23 months in Chitipa. In 2002, immunization coverage in Chitipa rose from 58% to 100%, through UNICEF's support of the cold chain system, but since the UNICEF direct cold chain assistance declined, coverage rates have dropped significantly. Nationwide measles mop-up campaigns were conducted November 2005 to improve overall coverage for under-twos. Maternal tetanus toxoid vaccination coverage rates stand at 85%, similar to rates recorded in 1992 and 2000 DHS surveys^{CVII}.

In just two years time, immunization coverage rates in Chitipa have dropped 30%. While present coverage rates of 70% are not alarming as such, the rapid decline from 100% just two years ago merits intervention to interrupt and reverse the trend. The MOH requires assistance with community mobilization and logistical support for outreach that the TPCSP will provide by adding immunization to its mix of C-IMCI interventions, adjusting the levels of effort for other interventions accordingly.

In response to factors that have contributed to this decline in coverage, the project will 1) teach caretakers about the importance of immunization in preventing deadly diseases, 2) mobilize community to access immunization services at HF and participate in MOH immunization outreach, 3) coordinate with MOH on immunization campaigns and provide ongoing technical and logistical support to MOH EPI teams, and 4) record immunization coverage statistics, support prompt and effective interventions for low coverage areas and identify defaulters for 'mop up' vaccinations.

The MOH is currently developing a more effective mechanism to address the logistical problems that have been associated with immunization, but the project will assist the MOH if needed. Logistical support for immunization will include transportation to outreach sites as needed, and occasionally assisting with fuel supply, if needed.

Caretakers will be encouraged to receive all age-appropriate vaccinations for their children right on schedule, and women will be encouraged to receive at least 2 doses of TT in pregnancy. Cases of vaccine preventable diseases identified by CG volunteers will be referred to appropriate HFs, and contact tracing facilitated. The project will help make complete immunization a norm that families and VHCs expect from the MOH, informing the

^{CVI} Malawi Preliminary DHS 2004

^{CVII} Malawi Preliminary DHS 2004

district when there are breakdowns in the system and holding the MOH accountable for EPI service delivery.

Vitamin A supplementation has been integrated into the MOH immunization program and children aged 6-59 months receive a dose of Vitamin A every six months. Project staff will strengthen MOH support systems for outreach activities since the MOH already has established mechanisms for vaccine transport and cold chain maintenance.

Additional messages will be provided at the household level to encourage increased dietary consumption of Vitamin A rich foods and cultivation of home and/or community gardens. The project will monitor immunization and Vitamin A coverage rates, and provide logistical support, including transport and personnel support to MOH staff during outreach campaigns. Vaccine availability and stock outs will be monitored closely, and mechanisms to forestall such occurrences will be built in to the MOH system.

Nutrition

Program Objectives:

- 1) 60% of children EBF for 0-6m
- 2) 70% of children 6-9m will receive complementary feeding
- 3) 60% of children 6-23 months receive appropriate number of dose(s) of Vitamin A per year.
- 4) 70% of children who complete HEARTH achieve and sustain adequate (200g) or catch-up (400g) growth per month for at least 2m after Hearth.

Malnutrition is endemic in Malawi, with 70% of U5 children chronically malnourished, 48% stunted, 22% severely stunted, and 5% wasted^{CVIII}. Malnutrition rates have remained stable in Malawi over the last two decades^{CIX} despite various interventions at community and national level. Exclusive breastfeeding rates for children under six months are 53%^{CX}, and 75% of under two month olds are exclusively breastfed. Complementary feeds are introduced early, though most children are still breastfeeding at 12 months of life^{CXI}. Complementary foods are generally of poor quality, and consumption of proteins, vitamin A- and iron-rich foods is uncommon^{CXII}. Micronutrient deficiencies are prevalent in Malawi, with 68% of U5s affected by anemia and 45% of women are anemic^{CXIII}. Causes of malnutrition in Malawi include household food insecurity, poor weaning and feeding practices, and recurrent infections. Salt iodization is not universal in Malawi, with 59% of households having iodized salt^{CXIV}. About 30% of children under 2 years are underweight in Chitipa. Malnutrition is multifactorial, although acute food shortages and seasonal food insecurity contribute a high percentage to the high levels of malnutrition reported in Chitipa District. Other factors include poverty, lack of food diversification, suboptimal feeding practices, taboos and high disease burden. Malnutrition and disease exist in a vicious cycle, with malnutrition increasing susceptibility to infection and infection tipping a poorly

^{CVIII} Malawi Preliminary DHS 2004

^{CIX} Malawi Preliminary DHS 2004

^{CX} Malawi Preliminary DHS 2004

^{CXI} Malawi DHS 2000

^{CXII} Malawi DHS 2000

^{CXIII} Malawi Preliminary DHS 2004

^{CXIV} Malawi DHS 2000

nourished child into severe malnutrition due to poor appetite, increased body metabolism, loss of body defense agents, etc. High prevalence of malnutrition in children results in depressed immunity and predisposition to high levels of morbidity and mortality from common illnesses. Suboptimal feeding practices including non-exclusive breastfeeding in the first 6 months of life, early introduction of complementary food (before 6m of life), abrupt weaning and withholding foods during illness, result in increased risk of malnutrition in under-fives. Specifically, the program will design messages to address practices that hinder adequate nutrition, such as withholding eggs from children and women, not eating pumpkin leaves except at certain times of the year, and refusing to offer rice when maize (the preferred staple) is unavailable.

Project interventions will encourage optimal infant and young child feeding practices, and maternal nutrition to ensure favorable pregnancy outcome, namely: 1) initiate BF immediately postpartum and within the first hour of birth 2) discourage and eliminate harmful BF practices and encourage BF on demand 3) maintain and support EBF for the first six months of life, especially for new mothers 4) introduce appropriate complementary food from 6m of life along with BF up to 2 years of age 5) encourage appropriate dietary management of the sick child according to IMCI guidelines (continued BF during illness, increased food and fluid intake during illness and for two weeks following illness; feeding the child fluids during illness, and prompt referral to HF if child exhibits danger signs of illness such as vomiting, inability to drink or eat, lethargy, fever, convulsions 6) promote receiving of vitamin A supplements every six months for children 6-59m old 7) encourage regular attendance of the caretakers and children at GMC 8) encourage pregnant women to consume more food during pregnancy and take iron supplements 9) encourage women to receive Vitamin A supplements immediately after delivery (up to 8 weeks postpartum).

Growth Monitoring sessions are conducted monthly by MOH staff during EPI outreaches, and CSP staff and volunteers will support the weighing, recording, checking of immunization status, delivery of vaccines, and nutrition counseling for mothers of children under five.

Caretakers of severely malnourished children will receive counseling and referral to the MOH staff for clinical evaluation for co-existing morbidities. Effective strategies for follow up of the malnourished child will be established through the CG structure. These strategies will include monthly weighing of malnourished children, follow up by CG volunteers of all children U5 within their block of households, recording weights in the road-to-health cards, and encouraging mothers of children with faltering weights to feed enriched porridge to these children to increase caloric and nutrient consumption. The CG leader will refer caretakers of malnourished children to the individual volunteer assigned to their households, for counseling and support as they learn to feed their children more nutritious meals. Weight and incidence of illness will be recorded during the GMC and the CG volunteer will follow up and monitor closely, every malnourished child in her 'block'. Children with severe malnutrition will be referred to appropriate HF for rehabilitation and treatment of co-existing morbidities.

In addition to the activities highlighted above, the project will use the Hearth approach to community-based rehabilitation of mildly and moderately malnourished children (<-1 and _2

Z scores, respectively) ages 12-36 months. The program manager has experience with Hearth in the previous project. However, the manual *Positive Deviance/Hearth: A Resource Guide for Sustainably Rehabilitating Malnourished Children* (Nutrition Working Group, Child Survival Collaborations and Resources Group, Washington, DC: December 2002) will be used as reference for Hearth activities.

Because levels of malnutrition are variable across the district, and resources for PD/Hearth activities are limited, the program will implement PD/Hearth in communities most affected by malnutrition. Levels of malnutrition will be determined using GM data to identify and children (and their caregivers) eligible for Hearth.

Positive deviance inquiries will be conducted by project staff and volunteers to identify those mothers who have well nourished children despite similar socio-economic status as their neighbors. The positive deviant practices will be analyzed in a group setting, engaging the community in the process of discovering the solutions that will be practiced in the Hearth sessions. Regardless of the specific positive deviant practices identified, Hearth sessions provide an opportunity for mothers and caregivers to practice preparing locally available nutrient-dense foods, using active feeding techniques, and practicing good hygiene and sanitation related to food handling and storage.

A Hearth cycle consists of 12 days of intensive group activity followed by two weeks of practice and follow-up in the home. During the first two weeks, identified children and their caregivers come together in a group every day except Sundays. Each family brings ingredients that contribute to the Hearth menu (to be influenced by the positive deviance inquiry) which the volunteers help mothers prepare together. The food eaten by the children during the Hearth session provides extra 600-800 kilocalories of nutrient dense food to be consumed daily in addition to the child's regular diet. The extra food facilitates catch-up growth on top of the child's regular energy needs.

All participating children will be weighed on the first and last days of the 12-day session, and thereafter at 1, 2, 6 and 12 months following the intensive two week period of Hearth sessions. Weight measurements will be recorded in Hearth registers which will be kept throughout the life of the project. Children who show adequate weight gain (>200g) or catch up growth (>400g) by the end of the first month will qualify for graduation, while those who do not will be invited for a second cycle. Reasons for non-response, such as underlying illness, will be explored and addressed if possible. For statistical purposes, only those children who attend nine of the twelve sessions will be counted as participants. Two to four hearth cycles will be repeated in the areas most affected by malnutrition, depending on need and responsiveness of children to the intervention.

During the course of a Hearth cycle, it is common for children's appetites to increase and for them to experience a "brightening" as their energy levels improve in response to the food. These changes, in addition to the documented changes in weight, help caregivers to understand the connection between food consumption and child growth and health. Success' stories will be disseminated widely to encourage participation from other caretakers of malnourished children.

The continuing food insecurity and rapid spread of HIV/AIDS may contribute to increased mortality and may mask the effects of these interventions. The project will increase its efforts to improve food security within the vulnerable communities in partnership with relief agencies, and advocate for assistance with seed and farm inputs for farmers, development of home gardens and food diversification.

HIV/AIDS Prevention and Reproductive Health

Program Objectives:

- 1) 70% of the mothers will deliver by a trained health provider**
- 2) 80% of caretakers will know at least 2 ways to reduce the risk of HIV/AIDS infection**

Malawi's national adult HIV/AIDS prevalence (14.2%) is one of the highest in sub-Saharan Africa, a situation worsened by poverty, ignorance of methods of preventing infection, harmful traditional practices, and stigmatization. Though knowledge of HIV/AIDS is near universal among adult Malawians^{CXV}, only 30% of women and 47% of men used condoms during sexual activity with non-cohabiting partners^{CXVI}. Only 8% of women and 16% of men reported that they had been tested for HIV. Voluntary Counseling and Testing (VCT) sites are available at all HCs in Chitipa, and ARV therapy and PMTCT services are available at the District Hospital. In 2000, one-third of women with STI in Northern Malawi received treatment from traditional healers, another one-third from friends or relatives, 19% from drug vendors, and only 22% from a HF^{CXVII}. Approximately 70,000 children under 15 years are infected with HIV/AIDS; and about 500,000 children under 18 years have been orphaned by AIDS^{CXVIII}, with over 11,000 children under 15 years having lost one or both parents, half of them due to HIV/AIDS.

Level of effort on HIV/AIDS and reproductive health was reduced in order to add immunization activities as already explained, narrowing measurable objectives to focus on delivery with a trained provider and prevention of HIV/AIDS. The continued emphasis on delivering with a trained provider sets the stage for participation PMTCT programs as they become available in the region.

Health education messages will include the following emphases: 1) delivery by a trained health provider, 2) recognition of symptoms of STD/HIV/AIDS, 3) knowledge of at least two ways to prevent STD/HIV/AIDS infections.

Sustainability: Sustainability of a child survival project can be considered from many dimensions. First and foremost, it is expected that positive health behaviors adopted during the life of the project will become normative and maintained in the community. World Relief's experience with care group volunteers in Mozambique and in *Embangweni* (former CSP in Malawi) have demonstrated that volunteer activity in the form of home visits and referral can be maintained after project end as well, continuing to reinforce maintenance of

^{CXV} Malawi DHS 2000

^{CXVI} Malawi Preliminary DHS Report 2004

^{CXVII} Malawi DHS 2000

^{CXVIII} Republic of Malawi National Plan of Action for Orphans and Vulnerable Children 2005 - 2009

behavior change. This particular project aspires to maintain the activity not only of individual volunteers but care groups as well, so that they continue to be a mechanism for mobilizing the community. The latter will require a particularly strong sense of community ownership and conviction that the work of the volunteers is making a difference in their community. The element of sustainability least under the project's control is related to MOH staffing and turnover, though MOH employees are included in appropriate capacity building exercises along with project staff, building the skills of MOH employees while strengthening ties between the MOH and community based CSP activities.

Working towards sustainability of care groups, the project deliberately engages community and church leaders (churches being one of the few long-term community structures) in program planning and implementation. Naming of the project *Tube Poka* ("All of us together") and of individual care groups (e.g. *Pachoko-Pachoko* – "Little by Little") contributes to a sense of community ownership that transcends World Relief as a facilitator of activities.

In addition to reinforcing volunteer participation in care groups by connecting them with community and church leaders for encouragement, it is also important that the care groups become an indispensable extension of the health system that reaches to the household level. Towards this end, HSAs are trained alongside project promoters developing the skills they will need to eventually train and supervise care groups themselves. By involving HSAs in training and working with the care groups from the beginning, they build relationships that are important in maintaining the volunteers in addition to becoming accustomed to working hand in hand with the volunteers to carry out household level BCC and assist with data collection that used to be burdensome when the responsibility of a single individual.

Integrating project HIS (collected by CG volunteers) data into the existing District MOH database is a strong indication that the DHMT has bought into the mission of the program and sustainability is being promoted from the outset. HSAs will gradually replace promoters in the second half of the program until they have full supervision of CGs. Senior HSAs will work closely with program supervisors to ensure optimal training and supervision of promoters and HSAs. Exchange visits between CGs from different parts of the district (and between old and new CSP areas) will be facilitated to promote unity and create a forum for information sharing and lessons learned. Linkage with VHCs and SWAs further strengthen the CG system and encourage easy integration into the community health system.

Engagement of community stakeholders in information gathering and sharing and ensuring timely feedback will promote sustainability. This the program will achieve through regular monthly meetings with DHMT, VHCs, church leaders and community leaders. CG volunteers will also share relevant HIS data with their respective households to encourage continued participation.

In addition to intervention-specific indicators, the project will also track indicators that reflect the activity and viability of the community structures that are essential to the project's successful implementation and long-term sustainability.

Table 8. Indicators for Capacity Building and Sustainability

IR	Indicators	Measurement Method	Activities
Capacity building for improved support systems	% of HSAs who receive C-IMCI training % of pastors who receive C-IMCI training % of traditional healers who receive C-IMCI training	Structured interviews, supervisory checklists, community data	Training and support for HSAs Training and supportive supervision of pastors and traditional healers
Sustainability	% of households visited by their volunteer in the previous two weeks; % of care groups with volunteer attendance of at least 70%. % of VHC who met in the last 2months % of CGs supervised by trained HSAs	LRA surveys, structured interviews, supervisory checklists, community data	Training and supervision of CG Linkage between CGs and HSAs, CGs and VHCs Training and supportive supervision for HSAs and VHC members Training and supervision of CG

Roles of Major Partners

MOH and Christian Mission HFs are the main providers of institutionalized curative services in Chitipa. World Relief complements these curative services by focusing on community-based activities that target WRA and children under five. In partnering with the Ministry of Health and SOL, TPCSP will focus on promoting positive behavior change at community and household level, and mobilizing communities to access available health services, while building MOH and SOL capacity to provide improved health services. It will also provide a strong linkage between the MOH and the community, a link that's virtually non-existent in some parts of the district. The SOL will play the lead role in providing a strong network between churches and between churches and the community, and the government system. Please refer to Annex G for updated MOUs between WR Malawi and partners.

Results Framework -- please see Annex K.

E4. Program Monitoring and Evaluation Plan

Current information system in the district: The current information system in Chitipa District is largely based on service delivery statistics that flow from the grass roots (TBAs, CBDAs) via health surveillance assistants to the level of the health facility, with service delivery data from multiple facilities converging at the district health office where they are compiled by a statistician who provides feedback to the community and sends aggregated results to the national level.

The CSP's M&E system introduces a new level of detail by regularly collecting data from the household level; this is in contrast to data presently collected by the ministry of health, which captures data on those who seek MOH services. With project surveys based on random sampling, the prevalence of diseases and health practices can be calculated for the population as a whole. Data reported by the community health information system has a known denominator because every beneficiary household is included. Both of these elements of the M&E system are described in more detail below.

The project CHIS will be integrated into the district health information system to facilitate appropriate disease surveillance and timely decision making by district MOH and CSP staff at community and facility levels. Those indicators that are common to the project and the MOH will be integrated into the existing MOH HIS, with CGs providing household level information which is not collected by HSAs in the current system. The village health register is an existing format for data collection that project volunteers can help to ensure is filled out more completely than may presently be the case. The Project will share CHIS information with the MOH during monthly meetings, on relevant indicators that are specific to the CSP, to promote evidence based decision making and timely interventions. Discussions about the best method of integrating both systems are ongoing between the MOH District Statistician and CSP Director to ensure meaningful integration takes place. CG volunteers will be part of community based data source groups who collect data and report to HSAs.

M&E Table:

The table below summarizes objectives, indicators, measurement method and activities pertaining to each objective.

Frequency of data collection is as follows: KPC surveys are conducted at baseline and end of project, Local Rapid Assessments are conducted after the phasing in of each intervention (about once every four months) until all interventions have been phased-in, decreasing to once every 6 months in the latter part of the project, and events captured by the community health information system (CHIS) are reported on monthly at care group meetings.

Table 9: Project Intervention Indicators

<i>Objectives</i>	<i>Indicators</i>	<i>Baseline</i>	<i>Methods</i>	<i>Activities</i>
Sick Child 80% of caregivers of children under 2 years of age know at least 2 danger signs of illness that require immediate treatment.	Percent of caregivers of children 0-23 months who know at least two danger signs of childhood illness that indicate the need for immediate treatment (e.g. lethargy, convulsions, vomiting everything, not able to drink, sunken eyes, dry mouth, no tears, loss of skin turgor, fever with diarrhea and/or dehydration) .	71%	KPC LRA	Train volunteers and caretakers to recognize danger signs and appropriate care seeking practices
50% of sick children will be offered increased fluids and continued feeding during illness	Children 0-23 months sick in previous 2 weeks offered increased fluids and continued feeding during illness. (Increased fluid and feeding correlates to breast milk for children under 6 months of age.)	4%	KPC LRA	Train volunteers and caretakers to continue feeding the sick child and to increase fluid intake
Immunization 80% of children 12-23 months-old will be fully vaccinated by their first birthday.	Percent of children 12-23 months fully vaccinated against the six vaccine-preventable diseases before their first birthday. (BCG, polio, DPT, & measles)	69%	KPC LRA	Coordinate EPI outreach with MOH; project volunteers mobilize community for immunization services.
Malaria 60% of children will sleep under ITNs.	Percent of children 0-23 months who slept under an insecticide-treated net the previous night.	41%	KPC LRA MOH Register	Train volunteers and caretakers in method of transmission and prevention with bed nets
50% of children with fever (suspected malaria) will seek treatment from a trained provider within 24 hours.	Percent of children 0-23months with fever (suspected malaria) in the previous 2 weeks who sought treatment from a trained provider within 24hours of illness onset.	17.5%	KPC LRA	Train volunteers to recognize signs of fever/malaria and importance of immediate treatment (within 24h)
Pneumonia Case Management 50% of children with rapid/difficult breathing (suspected pneumonia) will seek treatment from a trained provider within 24 hours.	Percent of children 0-23 months-old with rapid, difficult breathing in previous 2 weeks (suspected pneumonia) who sought treatment from a trained provider <24h	18%	KPC LRA	Train volunteers and caretakers to recognize cough and fast/difficult breathing as signs of pneumonia, to seek treatment in a HF within 24h for cough and fast/difficult breathing
Control of Diarrheal Disease 60% of children with diarrhea treated with ORT	Percent of children 0-23 months old with diarrhea in the previous two weeks who received ORT (home available fluids or ORS).	59.9% DHS 1994	KPC LRA	Train volunteers and caretakers to continue feeding the sick child and to increase fluid intake
60% of caregivers wash hands before food preparation, before child feeding, after defecation and after handling child's feces	Percent of caregivers of children 0-23 months who report washing their hands with soap/ash before food preparation, before child feeding, after defecation and after attending to a child who has defecated.	35%	KPC LRA	Train volunteers and caregivers in desired hygiene and hand washing practices; promote hand washing stations in the home.

Nutrition 60% of children are exclusively breastfed for the first six months.	Percent of children 0-5 months who were exclusively breastfed during the past 24 hours, based on dietary recall.	40%	KPC LRA	Train volunteers to counsel caretakers on importance of EBF and support EBF
70% of children 6-9 months receive complementary feeding	Percent of children 6-9 months who received breast milk and complementary foods during the last 24 hours, based on dietary recall.	40%	KPC LRA	Train volunteers and caretakers on importance of appropriate and adequate complementary feeding
60% of children 6-23 months receive appropriate number of dose(s) of Vitamin A per year.	Percent of children 6-11 months who received at least 1 dose of Vitamin A and children 12-23 months who received at least 2 doses of Vitamin A in the previous 12 months, as evidenced by card.	54%	KPC LRA	Train volunteers and pastors on importance of VAC supplementation Mobilize community to access VAC from community drug kits, mobile clinics and national campaigns
70% of children who complete Hearth achieve and sustain adequate (200g) or catch up (400g) growth per month for at least 2m after HEARTH	Percent of malnourished children who complete 12 days of Hearth achieve adequate (200g) or catch-up (400g) growth for at least 2 months after Hearth.	NA	Hearth program register data and follow-up	Train volunteers in Hearth methodology Conduct 2 Hearth cycles in the first 2 years, repeat in 3 rd and 4 th years as required. Monitor coverage in bimonthly GMC sessions Maintain HEARTH registers
STI/HIV/AIDS 80% of caregivers of children will know at least 2 ways to reduce the risk of HIV infection.	Percent of caregivers with children 0-23 months who cite at least two known ways of reducing the risk of HIV infection.	67.5%	KPC LRA	Train volunteers and caretakers on causes and prevention of STI/HIV/AIDS Promote increased demand and utilization of VCT services
70% of deliveries will be attended by a trained provider.	Percent of children age 0-23 months whose births were attended by skilled health personnel.	55%	KPC LRA	Train volunteers and caretakers on importance of ANC and encourage delivery by trained health provider

Measuring Sustainability: The table below describes project objectives for sustainable impact and the methods that will be used to measure progress toward sustainability.

The project will begin monitoring sustainability during the second year of implementation. Frequency of data collection is as follows: Project supervisors and promoters and HSAs will monitor supervisory checklists and project records monthly. Monitoring the status of pastors, traditional healers and VHCs will occur quarterly.

Table 10: Monitoring Capacity Building and Sustainability

<i>Objective</i>	<i>Measurement Method</i>
Capacity Building	
80% HSAs receive C-IMCI training	Project and District Records
80% of pastors receive training in C-IMCI	Project Records
60% of traditional healers receive training in C-IMCI	Project Records
Sustainability	
70% of care groups with volunteer attendance of at least 70%	Supervisory checklists
60% of VHC met in the last 2 months	Community data
70% of CGs will be supervised by trained HSAs	Project records
70% of households visited by their volunteer in the previous 2 weeks	LRA survey

Data quality: Several principles that World Relief follows for data collection and use contribute to maintaining good data quality. First and foremost, those involved in data collection are also involved in its analysis and discussion of results. This makes the maintenance of good data quality relevant to those who are collecting and manipulating it. Furthermore, supervision and spot checks at each level of data collection and tabulation identifies problems and allows for investigation to make sure that errors are limited to isolated instances, allowing for correction without becoming systemic.

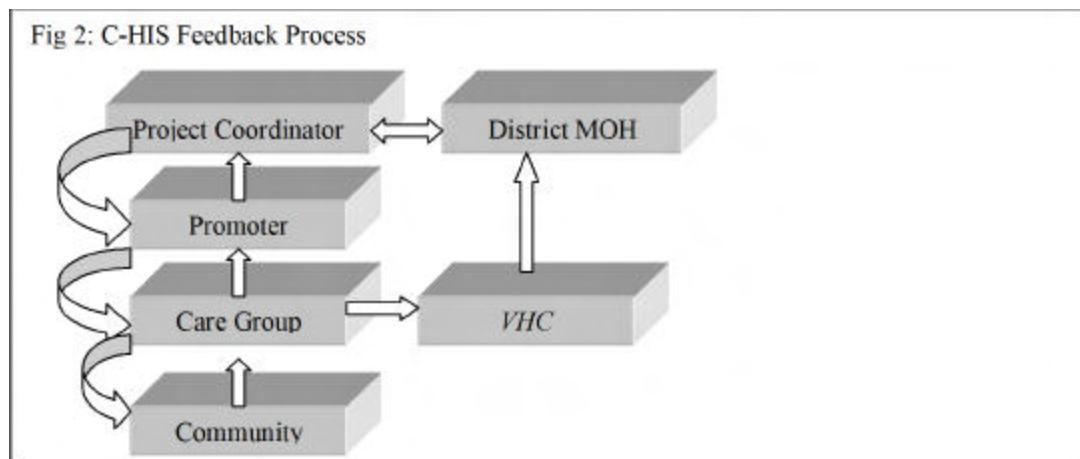
Baseline, Midterm and Final Evaluations: Standardized Knowledge Practice Coverage (KPC) 30 cluster surveys will be conducted at baseline and final to determine project performance using KPC 2000+ modules that include the Rapid Catch indicators. The modules will be translated and pre-tested for local use. Results of the surveys will be disseminated to the key community and MOH stakeholders for illustrating the health status of the population and the achievements toward objectives.

Monitoring Surveys: Local Rapid Assessments (LRA) are conducted using select indicators from the KPC 2000+ modules to create a snapshot of project progress at regular intervals during project implementation. The purpose of the monitoring surveys is to track progress and identify problems with plenty of time for correction and modification of strategy if needed. The sampling method is stratified in order to create a sample that is reflective of the different geographic supervision areas of the project. LRA surveys are conducted after the phasing in of each intervention (about every four months). In the latter half of the project, after all interventions have been introduced the first time, monitoring surveys will be conducted slightly less frequently, decreasing to two per year. The first LRA was conducted in April 2006, following introduction of the malaria intervention. It also served to establish a baseline for isolated rapid catch indicators (not related to malaria) omitted at the time of the baseline KPC Survey. Results are disseminated to stakeholders of the program, including the MOH at provincial, district and HF/HC levels, VHC, Pastoral and traditional healer CG, and Volunteer CG for discussion and effective decision making.

Monthly Mortality Statistics: Cause and incidence of deaths for children U5 (<1y, 1-4y) will be recorded every month by the volunteers using predetermined criteria and aggregated by the project staff. The animators ensure that the data covers the entire community by conducting follow-up visits with volunteers who are absent from CG.

CHIS: The CHIS is designed for community level monitoring. Volunteers obtain information on vital statistics and other pertinent information about incidence of illness. During every CG meeting per month, each volunteer reports on pregnancies, births, deaths, and individual women and children at risk of disease or MN. The CG leader records the information and reports it to the project staff. This information is shared to help the CG and VHC identify and address problems, overcome barriers, and measure progress towards objectives. It also enables volunteers and village leaders to identify households at risk and to take appropriate community action. Promoters will encourage volunteers and CG to find a medium (graphs, pictures, etc) of sharing information appropriate for their village, and display in a location with easy access to all (school, churches, chief's house). Information flows to the District

level MOH via the HSAs and is cross-checked by parallel tabulation by the promoter and district level CSP staff. In addition to allowing for verification of data, the parallel information flow directly from the community to MOH channels promotes sustainability after project end.



Verbal Autopsy:

Using a simplified verbal autopsy tool, the C-HIS provides a method of monitoring childhood deaths and their causes. Incidence and cause of deaths in children U5 (<1y, 1-4y) will be recorded every month by volunteers using predetermined criteria and aggregated by project staff who undertake additional inquiry when required to clarify cause of death. This tool serves as a critical surveillance instrument to record variations in seasonal mortality or to sound an early alarm to address problems either at the community or health center level. The C-HIS also permits the calculation of child and infant mortality rates.

MOH Service Statistics: Information routinely collected by the MOH at the district level on consultations will also be used to determine service utilization and coverage in the health posts and health centers and monitor interventions especially for VCT services.

Qualitative Data: Focus group discussions and key informant interviews using standard methodologies were conducted as part of formative research with caregivers to determine local perceptions and beliefs, local terms for illness, health priorities, and barriers to care-seeking. Training of interviewers, description of informants and a summary of results is discussed in Section E2.. Additionally, every care group meeting is an opportunity for increasing qualitative understanding of what is happening in the communities. Volunteers help project staff and HSAs to understand the beliefs and practices of their neighbors, particularly when things are not going as expected.

Staff Performance will be evaluated through various methods of testing including individual and peer assessments of knowledge and performance using selected criteria. Promoters will be evaluated and ranked on a scale of 1-5 based on the following criteria: knowledge of interventions, training skills, performance of volunteers under supervision, results of quarterly C-HIS for the households of his/her volunteers. Volunteers will be tested on

knowledge and performance. Each CG is expected to achieve an aggregate score of 60%; those that fail to achieve this score will be retrained and retested after one month. Strong volunteers will be paired with weak volunteers for home visits until they gain confidence.

Observation of *Provider Performance* at the HF and HF provider and caretaker interviews along with record reviews will be conducted to determine quality of services for IMCI using the IMCI HFA tools that have been standardized for measuring provider performance. Record reviews will include information on availability of essential drugs and vaccines for IMCI, transport, and use of health education materials. Community capacity development will be measured using criteria that include communication links between the groups, use of local leaders, functionality of VHC, and monthly meetings of pastoral and traditional healer CG.

Organizational Performance: Every two weeks the Project Director, Deputy Director, District Coordinators and Supervisors will meet to discuss results and challenges. These meetings are opportunities for quality improvement as staff identify opportunities for improvement, define problems, establish desired outcomes and plan steps to achieve them. District Coordinators will attend MOH staff meetings to share feedback on results. The LRA surveys and training workshops mark quarterly cycles of information gathering and organizational reflection. The Project Director is responsible to collect and analyze data on limiting factors and will plan corrective action and monitor results in conjunction with the Province liaison for CS. At Headquarters the team will conduct Institutional Strengths Assessment in accordance with the cooperative agreement.

Supportive Supervision: All project staff will be fluent in the local language to enhance communication and cultural understanding. Personal feedback is essential for motivation and timely problem solving to ensure continuous quality improvement. The district coordinators and supervisors will visit the project staff in their villages, and assess progress through interviews and observations using standardized supervisory checklists and project indicators. The project director will continue to work within the MOH, and will monitor coverage, quality and needs of the health system and access to MOH statistics (e.g. EPI coverage, malaria cases treated, mortalities and morbidities).

The project managers and Health Education (HE) Supervisors will meet monthly to discuss results and challenges. These meetings are opportunities for quality improvement as staff identify opportunities for improvement, define problems, establish desired outcomes and plan steps to achieve them. HE Supervisors will attend staff meetings with MOH for the health facilities in their area to coordinate activities locally and share feedback on results. At project level, the Project Manager and Deputy will participate in quarterly DHMT meetings. Community capacity development will be measured using criteria that include communication links between the groups, use of local leaders, functionality of VHC, monthly meetings of pastoral and traditional healer CG.

Monitoring Tools: This project benefits from being World Relief's second CSP in Malawi. Consequently, many of the tools used for data collection have already been tested and used in a similar context. The project manager has overall responsibility for leading the process of adapting instruments to the new context. When needed, the PM consults with the Child

Survival Specialist for technical support in all matters, including monitoring and evaluation. The Health Facility Assessment forms, Focus Group Discussion guide used at baseline and LRA sampling methodology are included in Annexes D, E, and F, respectively. A monitoring checklist for care group training will be adapted from a previous project by the Project Director in consultation with the Child Survival Specialist.

Data analysis and results dissemination: Data from the C-HIS will be discussed at the level of the care group when vital events are reported, particularly in the case of a child death. Data are aggregated at the district level both by project staff and the district statistician, both to corroborate results and to establish a means of data flow that is not dependent on project staff. Summary results will be shared back with the care groups as well as the VHCs and other community groups who will use the results for local decision making and community accountability. Results from the C-HIS and project surveys shared with VHCs will also help them to advocate for immunization and other expected services. Anticipated disparities in treatment seeking practices according to distribution of HSAs and health posts will be used to advocate for the placement of additional HSAs and/or DRFs to improve access to first line treatment for malaria and pneumonia.

Quality of services: In partnership with the MOH, the project plans to conduct a Health Facility Assessment in May 2006 using the instrument in Annex D. Findings from the HFA will be used to identify areas requiring reinforcement and set goals for performance improvement. A follow-up assessment will be conducted in year four of the project.

Responsibility for M&E: The project director is responsible for oversight of the project's monitoring and evaluation activities. The director receives technical support for M&E from the Child Survival Specialist, Dr. Olubukola Ojuola and other members of the Maternal and Child Health team at World Relief in Baltimore. The partner communities participate most actively in the data collection for the community health information system. Village Health Committees incorporate data from both the C-HIS and project surveys into their decision making at community level. Project promoters assist them initially with interpreting the data as needed.

Capacity building in M&E: The CSP does not expect staff and partners at the local level to have sophisticated skills specific to the project's M&E systems. Consequently, staff and partners are included together in training before the use of each tool or instrument for data collection. The Deputy Director attended a workshop on Care Groups put on by World Relief in Mozambique. This included presentation of M&E systems used in conjunction with care groups with which the Malawi Program Director was already familiar and able to provide follow-up support for the Deputy in-country. Opportunities will be sought to send the director and/or deputy director to relevant local and regional trainings put on by CORE, CSTS or PVOs for the purpose of increasing staff expertise with regard to M&E. Project leaders are then expected to translate what they learn at such trainings to the appropriate level of other staff and partners.

Sustainability of M&E System: While it is not expected that project surveys would continue without paid staff to conduct interviews and tabulate results, the community health

information system is sustainable insofar as the volunteers continue to visit their caseload of 10 households and report vital events to the HSA or other community health worker for sharing with the village health committee and aggregation at the district level. A similar design has proved to be sustainable in Chokwe, Mozambique following conclusion of World Relief's Vurhonga 2 child survival project. In addition to being contingent on maintaining volunteer activity, sustainability of the C-HIS will depend on the use of the data by village health committees and communication of its impact, along with a hearty dose of thanks, to those collecting the data. Furthermore, at the district level, the additional data provided by the C-HIS needs to become institutionalized so as not to be lost upon inevitable staff turnover.

Operations research: Please refer to Section D. Revisions for changes in OR plans.

CSHGP Program Results: The project will contribute to the CSHGP Program Results as outlined in Table 11 below:

CSHGP Objective	Project Contribution
PR1: Improved Health Status of Vulnerable Target Populations	
PR1.1: Increased knowledge and improved health practices and coverage related to key health problems and interventions.	Project interventions including BCC and related support services in the areas of malaria, pneumonia, malnutrition, diarrhea, HIV/AIDS and immunization. Measured according to objectives outlined in above M&E table.
PR1.2: Improved quality and availability of key health services at health facilities and within communities.	Create accountability for provision of quality health services via health facility assessments.
PR1.3: Increased capacity of communities, local governments and local partners to effectively address local health needs.	Functioning care groups of volunteers, active village health committees, and increased capacity of district MOH to respond to needs at household level.
PR2: Increase Scale of Health Interventions	
PR2.3: Widespread development or adoption of innovative approaches.	World Relief serving as model for other NGOs considering use of care groups for training and sustaining volunteers in Malawi. Ongoing negotiation with MOH for scale up of care group approach on wider level according to national priorities.
PR2.4: Improved collaboration with USAID missions.	Successful development of project proposal and plans in consultation with Mission staff.
PR3: Increased contribution to CSHGP to the global capacity and leadership for child survival and health.	
PR3.2: Improved recognition and visibility of PVO work in health. Increased	World Relief will submit abstracts with project results for dissemination at

opportunities for supporting technical excellence.

international health forums.

Table 12: Conformance of CSP activities with USAID mission priorities

<i>USAID Mission Priorities</i>	<i>CSP Supporting Activities</i>
<i>KIR8.2: Reduced New HIV Infections</i>	ABC behavior change interventions/VCT
<i>KIR8.4: Reduced Child Morbidity (improved prevention and management of child illness and increased use of malaria prevention practices)</i>	Households trained to adopt C-IMCI practices, Children and pregnant women sleep under ITNs, etc. (Majority of project objectives support)
<i>KIR8.5: Increased Effectiveness of Health Care Systems</i>	Build capacity of HSA, through CG, create awareness and demand for VCT services, supportive role for training, HIS, outreach, and improved quality of services.

Evaluation plan: In addition to the routine project monitoring described above, the project will undertake formal evaluations lead by USAID-approved evaluation team leaders at mid-term and end of project. Specific dates for evaluations will need to be coordinated with the team leader's schedule. However, the proposed timeframe for the midterm evaluation is July of 2007 and for the final evaluation August 2009.

E5. Program Management

Organizational Structure:

To build technical and operational capacity within the district and community health systems, Tube Poka CSP is a partnership between WR Malawi, Chitipa District MOH, and a network of local churches led by the SOL and the communities of Chitipa (refer annex PX - organizational chart, for further details).

District MOH Management Structure: at the district level, the District Health Officer (DHO) provides overall leadership for all facility-based health activities and coordinates community-based activities by working with various community-based organizations. The DHO provides direct supervision to the DHMT, a team made up of four health officers who are responsible for maintaining the quality of services provided at HFs. Each HF has a lead officer, the 'In Charge', who supervises health services provided by Senior HSAs and HSAs. Senior HSAs provide training and supportive supervision to HSAs, and where there are no Senior HSAs, this role is filled by Health Center nurses or health assistants, who are based at HFs in the catchment area of respective HSAs. HSAs provide basic health services at HPs, as well as conduct integrated outreaches at mobile clinics and mobilize communities to access available services.

Churches in Chitipa: Churches in Chitipa have long been involved in community health, with church-based ITN committees, water and sanitation projects and HIV/AIDS projects. Volunteer selection for the project was completed collaboratively both with church and

community leaders. Using materials adapted from those used with volunteers, the project is training church leaders the same health lessons the volunteers deliver. This provides reinforcement of key messages and consistency of information. In addition, churches provide support and encouragement to care groups, which aids in the sustainability of the project. With a population that is 96% Christian, there are a number and variety of churches in Chitipa. The Church of Central Africa Presbyterian (a.k.a. Synod of Livingstonia or SOL) is the largest denomination, with many satellite churches throughout the district. Others include the Catholic Church, Assemblies of God, and Baptists, as well as several smaller denominations.

SOL Management Structure: The PHC Coordinator of the SOL reports to the SOL Health Department. The SOL has 2 HF in Chitipa as well as a community-based HIV/AIDS program. Building on the existing relationship between WR and SOL, and SOL's involvement in community-based health programs, the SOL will take the lead in coordinating activities between partner churches in Chitipa. WR will coordinate activities between the SOL, the District MOH and other local partners. CG volunteers will receive training and supervision from program and MOH staff, while local church partners will provide much needed encouragement to volunteers at the community level. Involvement with the care groups adds strength and number to the churches already involved in promoting community health activities. WR regional office in Mzuzu is housed within SOL premises, facilitating communication and exchange of ideas.

Communities: Village headmen and other major stakeholders at community level are engaged in program design, planning and evaluation. The program is building support for the CG system by involving village leaders in program design and planning. Program assessment results will be shared with village headmen. In addition, VHCs, ITN committees, and other community-based players are engaged in the program planning and implementation process.

WR CSP Management Structure: Tube Poka CSP Director is responsible for direct program implementation in Chitipa, including such aspects as program planning, staff recruitment, training and supervision; managing partner relationships, including maintaining good communication with USAID mission and other bilateral organizations, and providing monthly reports to the HQ technical team. The Program Director reports to WR Malawi Country Director who provides oversight and management support to all WR programs in Malawi. The CSP Deputy Director, who is based in Chitipa, provides direct supervision for program implementation. He is mentored by the Program Director, who also serves as his line manager. Seven Health Education Supervisors (HES) provide training and supervision to thirty-two promoters who in turn train and supervise 3060 CG volunteers organized into 306 CGs.

WR HQ: The MCH technical team, based at WR Headquarters in Baltimore, provides the field team with technical support and guidance while managing grant reporting relationships

with USAID/Washington. The Child Survival Specialist, a pediatrician and public health specialist, provides primary technical support to the program, and is supervised by the Director of MCH Programs, who has extensive CS programming experience and strong M&E skills. The MCH program officer, also an MPH graduate, provides backup support, particularly when the other members of the team are traveling. The full list of support staff and their reporting relationships is included in the organizational chart and the CVs of newly appointed staff are included in Annex I.

Considerable effort is given to developing effective communication mechanisms that will ensure optimal program implementation. Regular planning and review meetings are held with major stakeholders in order to review existing structures and develop innovative strategies to ensure smooth program delivery. Involving stakeholders in program monitoring and evaluation activities will facilitate mutual accountability among stakeholders at all levels:

Level 1: DHO and Program Director. Strategic meetings are planned at the District hospital on a quarterly basis for joint planning and review of progress with the District Health Officer. The Program Director will also participate in the District Planning Secretariat, which convenes every month, or with the District Assembly, for joint coordination of activities. The CSP Director will be in regular dialogue with the DHMT to coordinate program planning and implementation. Together, they will agree on the most effective means of achieving program objectives and sustaining positive behavior changes.

Level 2: Health Center In-Charges and Health Education Supervisors. Health Education Supervisors regularly coordinate local plans for MOH HSAs alongside promoters, and they work closely with HF In-Charges and other NGO programs that exist in their areas. HESs will meet with Senior HSAs, health promoters and HSAs every two weeks to share information, review activity plans, troubleshoot problems, and train and supervise promoters and Senior HSAs.

Level 3: Senior HSAs/HSAs and Promoters. HSAs will be trained to function as promoters and to mentor CG volunteers, in the interest of sustainability. CGs will be integrated into the MOH system by promoting HSA supervision of CGs, joint training of CGs with promoters and M&E system maintenance by HSAs. As soon as the CG system is fully functional (i.e. all volunteers are assigned HH, and promoters are training and supervising CGs smoothly), HSAs will assume direct training and supervision of some CGs, and their performance will be monitored closely by program Health Education Supervisors (HES). HSAs will receive no financial incentive from the program as they fill this role, but will benefit from the results of the CGs' work in their communities.

Level 4: HSA and CG. Promoters and HSAs will be trained jointly to train and supervise CGs. HSAs will meet with CGs in their catchment areas at regular intervals. It is in the interest of HSAs to work with care groups since the care group volunteers assist with their regular job duties pertaining to community education, mobilization and data collection.

Vertical and horizontal linkages described above will facilitate an integrated and sustainable approach to mobilizing the community for care seeking and outreach activities.

Monthly meetings will be held between HESs and CSP directors to plan and review program activities, evaluate progress, and address critical issues. Starting in the second year, these meetings will be held every quarter. The Deputy Director will build the capacity of the HESs in developing work plans that will guide their daily, weekly and monthly activities, in compliance with outlined DIP plans. In addition, he will facilitate partner meetings, such as project staff and the DHMT, church leaders and program staff, community leaders and church leaders, etc. Standard tools for assessing and improving performance including supervision checklists will be utilized at each level for staff performance assessments.

The CSP will maintain an office in Mzuzu to facilitate access to banking and communication outside of the district. An administrative assistant, accounts officer and driver will be based in Mzuzu to facilitate operations. Mzuzu is also the base for the Program Director, when not in Chitipa or representing the program in Lilongwe. In the Chitipa office, an administrative assistant and accounts clerk will provide support to the Deputy Program Director and CSP team based in Chitipa. The office provided to the program by the MOH within the District Hospital premises will serve primarily as a meeting place for the MOH staff and other partners because it is too small to house the entire program staff. The project office will be maintained and the program will be administered primarily from that site.

HESs has been assigned geographic areas of supervision as follows: 4 HE Supervisors from Chitipa Hospital cover Chitipa Central; another team of 2 HE Supervisors will be based in the Nthalire Corridor and one HE Supervisor in Misuku, thus covering the entire district. HESs has been assigned office spaces at HFs in Wenya and Misuku. This has facilitated close relationships and field-based supportive supervision. At village level, HE Supervisors relate to VHCs, churches and schools in addition to the HF and mobile outreach activities taking place in the area.

Technical Support: The program will receive at least one technical support visit from HQ staff per year, with additional visits as required: 1) 2 weeks in Y1 for DIP development, 2) 1.5 weeks at the end of Y1 to assist with writing the first annual report, 3) 2 weeks for the Midterm Evaluation in Y2, 4) 1.5 weeks at the end of Y3 to monitor progress post-MTE, and assess progress towards achieving EOP objectives, 5) 2 weeks for the Final evaluation. Additional face to face contact in year one was facilitated by participation of the Deputy Director in a workshop on care groups in Mozambique co-facilitated by HQ MCH staff, as well as the Director's anticipated visit to Headquarters for the Mini-University and DIP Review..

The Program Director will submit monthly progress reports to HQ and maintain weekly communication by email, fax or phone as required. HQ technical staff will provide periodic updates on technical information and strategic changes in the intervention areas and promote dissemination of program results, best practices and lessons learned at national, regional and international forums. Opportunities for professional growth will also be identified, and the

HQ team will facilitate field staff participation in such programs. Staff will be encouraged to attend regional and international trainings to build their capacity in technical areas and staff management. Consultants will be hired (preferably regionally) to provide training in technical areas where such training will be relevant. The Deputy Program Director participated in the Care Group Workshop held in Mozambique in March, 2006, which was a great opportunity to see the World Relief's 'model' project using CG and to discuss ways the Malawi program might be able to learn from experience elsewhere.

Financial Management: WR HQ is directly responsible for the financial management of the project as the finance departments are well experienced with the requirements of managing and reporting USAID grants. The project accountant provides reports on a monthly basis to the country accounting staff in Malawi, which is processed by WR HQ for reports to USAID. At the field level, the Program Director or Deputy Program Director is responsible for approving expenditure and reimbursement requests of HES and other staff. The administrative assistant procures items not available locally, receiving multiple quotes before procuring equipment and supplies. The accountant manages the project's financial books, participates in audits and prepares reconciliations, wire transfer requests, and monthly financial reports. The country-level accountant and financial manager provide support and supervision to the assistant accountant in Mzuzu and office assistant in Chitipa (for admin and finance services), and assist the director in managing the budget.

E6. TRAINING PLAN: World Relief Malawi Child Survival Project (Table 13)

Training Activities	Year 1 (FY06)	Year 2 (FY07)	Year 3 (FY08)	Year 4 (FY09)	Technical Resources		Target Group (s)	
					Materials	Personnel		
<i>Phasing in Interventions</i>								
Malaria						C-IMCI Policy, Malaria Control Policy, Training Curriculum	Project Directors, MoH MCH Coordinator, DEHO	<ul style="list-style-type: none">• Health Education Supervisors• Health Promoters• Health Surveillance Assistants• Care Group Volunteers• Household members
Pneumonia						C-IMCI Policy, Training Curriculum	Project Directors, MoH MCH Coordinator, DEHO	<ul style="list-style-type: none">• Health Education Supervisors• Health Promoters• Health Surveillance

Training Activities	Year 1 (FY06)	Year 2 (FY07)	Year 3 (FY08)	Year 4 (FY09)	Technical Resources		Target Group (s)
					Materials	Personnel	
Care Group Volunteers train households					Training curriculum, Songs, Picture Codes, Role plays, Stories	Care Group Volunteers	Households
Train Health Facility Staff in the use of C-HIS statistics and supervision					C-HIS Statistics, MoH HIMS Policy	District Statistician, HESs, Project Directors, DEHO	Health Surveillance Assistants, Health Promoters
Train Traditional Healers to identify risk factors and referral system					Training Guides	HESs, Health Centre In Charges	Traditional Healers
Train VHC leaders how to conduct meetings and supervision, visioning of HIS					Training Materials	HESs, Project Directors, MCH Coordinator.	Village Health Committee, Care Group Zonal Committees.
One week Refresher Training at each new intervention					Training Curriculum	HES, DEHO, Project Director	Health Promoters, Community Development Assistants, Social Welfare Assistants, Senior Health Surveillance Assistants.
Retraining in use of ITNs					Training Materials	Malaria Control Coordinator, HESs, Project Directors	ITN Committee Members
Project Management for non managers Training					Training Materials	Consultant, Project Directors, DEHO	Village Chiefs, HESs
Qualitative Research methods					Training Materials	Consultant	HESs, Health Facility personnel

E7. WR Malawi CSP WORK PLAN (Table 14)

	FY06				FY07				FY08				FY09			
Quarter	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Project Activities																
Orientation with District Planning Secretariat and the Church regarding CSP program and expectations	x															
Office set up in Mzuzu & Chitipa	x											x				
Meetings with local leaders to invite their role in community activities	X															
Recruit core staff	X															
Intervention training/refresher for core staff	X					x				x				x		
Train CSPcore staff and MoHP in KPC and census survey methodology	x															
Recruit volunteers and form care groups	x															
Equipment procurement	x															
Conduct KPC, census	x															
Compile KPC, census reports, share findings with stakeholders-clarify sustainability objectives	x	X														
Consult with stakeholders: share KPC, census findings, discuss progress toward sustainability.		x														
Compile and submit monthly reports	x	X	x	x	X	x	x	x	x	x	X	x	x	x	X	X
Curriculum Development			x	x	X	x	x	x	x	x						
Qualitative Research			x				x				X					
Staff retreat-team building, skill building				x				x				x			x	
Produce and submit DIP		x														
Formation and training of care group Zonal Committees		x	X													
Identify and train DRF and ITN volunteers		x				x										
Conduct refresher training																
Malaria/Pneumonia Intervention		x	X	x	X											
Set up monitoring system and tools, incl. HIS		x														
Conduct Health Facility Assessments		x									x					
Nutrition intervention-Hearth			x	x	x											
Train core team, promoters, HSA and care groups in Hearth methodology-Implement Hearth cycles			X			x										
Local Rapid Assessment			X	x	X	x	x		x		X		x		x	
DIP Presentation, Washington DC			X													
Incorporate recommendations made at DIP review				x												
Annual Reports				x								x				
Promoter and Volunteer performance review				x				x				x				
Procure and Distribute volunteer incentive T-shirts				x				x				x				X
Nutrition assessment				x							X					
Activities related to strengthening VHCs							x				X					
Family Planning and HIV/STI Interventions					X											
Enhance Community based HIS				x	X	x	x	x	x	x	x	x	x	x	x	X
Midterm/Final Evaluation								x							X	X
Implement MTE Recommendations								x								
Disseminate evaluation findings to stakeholders								X								X
Discussions with MoHP: program exit strategies											x					
Documentation of program achievements					x				x				X			

**GH/HIDN Child Survival and Health Grants Program
Debriefing Summary Sheet
FY 2005**

PVO: World Relief Corporation

Country: Malawi

Category: Standard

Categories	Entry	Standard	TB	Expanded
Number reviewed	11	12	8	10
Number funded	4	5	2	4
Highest score	N/A	97.78%	N/A	N/A
Lowest score	N/A	82.20%	N/A	N/A
% Overall Funded	25%	35%	15%	25%
PVO App. Rank	N/A	5	N/A	N/A
PVO App. Score	N/A	95.57%	N/A	N/A

Individual Category Scores for Standard: (Maximum Points in Parentheses)

Executive Summary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Performance M&E	Management Plan	Collaboration w/USAID Mission	Total Points
(2)	(8)	(25)	(25)	(25)	(10)	(5)	(100)
1.93	8	24.22	23.02	24.06	9.53	4.81	95.57

SUMMARY COMMENTS

Name of PVO applicant: World Relief

Name of Country: Malawi

Application Category: Standard

EXECUTIVE SUMMARY

Strengths

This section is well written and complete, giving a good overview of the project. It clearly identifies the target population and highlights the fact that the target district, Chitipa, is identified as one of the most vulnerable districts in Malawi. It provides a concise picture of how the grant will be implemented, with assistance of the Ministry of health and the Presbyterian Synod, especially highlighting their unique "care group" volunteer approach supported by health promoters.

Weaknesses

Some attention should be given to ensuring the accuracy of the cited references on sources of information.

DESCRIPTION OF THE PVO APPLICANT

Strengths

The proposal is consistent with WR's organizational mission and its other programs worldwide. While its programs serve those in need regardless of religious affiliation, it proposes to capitalize on its religious orientation by working extensively through local churches. WR's faith-based, Christian emphasis lends itself to the type of partnership arrangement they have in Malawi with the Church of Central African Presbyterian (CCAP) Synod. Its work in food security and with PEPFAR's HIV/AIDS focused-activities offers additional opportunities for synergy.

WR has extensive experience in child survival and in Malawi. Through its previous Malawi child survival project (in the same region) it was involved in adapting the community IMCI (C-IMCI) approach. It has a strong results-oriented approach. It has been able to demonstrate significant successes in reducing morbidity and mortality, particularly targeting those indicators that are tracked by the USAID/Malawi program.

WR has used its other child survival projects to develop, replicate, and evaluate a "Care Group" model which provides the foundation for its proposed community interventions in Chitipa. This impressive model claims above 90% volunteer retention rates for extended periods during programs and after in both Mozambique and Malawi. The documented increases in early treatment for fever, children sleeping under an ITN, high levels of

exclusive breastfeeding are very difficult to do and serve as an important model to be expanded and replicated.

The current proposal was developed at the request of the District Management Team in Chitipa after they saw the work of the previous child survival project in the neighboring districts.

Weaknesses

Based on WR's extensive experience and the successful results of its Care Group approach, WR should be working at a more national level demonstrating that this approach can be implemented at scale nationally and regionally, rather than continuing to implement at small scale district levels.

It would be helpful to clarify whether the information presented in Table 2 is raw numbers or percentages.

SITUATIONAL ANALYSIS

Strengths

There is health status information for the national level on fertility, mortality, morbidity particularly for malnutrition, malaria, pneumonia, diarrhea, and HIV/AIDS, and a description of the status of key intervention strategies such as C-IMCI and orphan care. The description demonstrates a sound understanding of the constraints and opportunities in Malawi, and shows good understanding of the major reasons for under-utilization of modern health care services. Health services including local health posts, personnel, and traditional healers and TBAs are described. The information provides justification for the project strategy of training community level service providers.

Descriptions of key household behaviors are provided and serve as a basis for development of the BCC strategy. This section includes a discussion of socio-economic factors particularly as they relate to food security and ability to pay for health services. This section clearly outlines the difficulties in access to care in this area.

There is necessary information to understand the impact of orphan status on child survival as well as how the project might mitigate this impact through its Care Group approach.

The letter from the MoH in Chitipa is a completed and signed Memorandum of Understanding outlining relative roles and responsibilities. The letter from the USAID Mission indicates strong support.

The description of other partners includes both the potential for synergy and clarification of roles and responsibilities, identifying how the partners' activities will complement those of the project. There is an opportunity to augment activities by extending food security activities into Chitipa.

Weaknesses

With WR's extensive local experience, there should be more specific information about the target district and beneficiaries. The reference that the target district is considered the most vulnerable district is based on an assessment from 1996 which is nearly 10 years old.

It would be helpful to clarify if the malaria data quoted refers to Malawi as a whole, the northern Region, or to Chitipa District. The reported incidence of malaria should be listed as per thousand population.

Adding the prevalence of stunting and wasting does not result in the proportion that is malnourished.

Beliefs about disease causation often influence treatment choices that are made at the household level. This section should go beyond a listing of traditional beliefs to include a major discussion of health seeking behavior in Chitipa.

PROGRAM STRATEGY AND INTERVENTIONS

Strengths

This section presents very coherent and well-integrated goals, objectives, strategies, and interventions. WR takes advantage of organizational lessons learned through other projects. The selected interventions are appropriate and reflect best practices and the constraints of the project population and environment. The project proposes to cover all three elements of the C-IMCI strategy.

The Care Group model is a well-developed and tested strategy. Neither motivation nor attrition has been a problem with this model. The proposal makes a good case for how this model is particularly appropriate for addressing the needs of orphans and families affected by HIV/AIDS. The description of the Care Groups and volunteers demonstrates a clear understanding of the existing community structures, culture, and needs in the area.

The strategy for training and supporting the community level program is well developed. WR focuses on the needed synergy with the local health partners, both District hospital staff and CHAM staff.

The malaria program strategy is well thought out. Proposed interventions are appropriate building on past IEC experience and successes.

The nutrition intervention identifies several very useful tools for community programs. The Annex provides good supporting information on the types of community level tools that will be used to track and encourage good nutrition practices for malnourished children and for exclusive breastfeeding.

The relationship with partners and other health activities in the area is a particular strength of this section. While the District MoH is the primary partner, the project will also be working with the Synod of Livingstonia, World Vision, and UNICEF. Informal services such as traditional healers, drug sellers, pastors, and village health committees are included.

The project appears to be consistent with MoH policies and approaches. WR will introduce their community health information system as a novel and innovative effort to link with the MoH system.

Weaknesses

This section needs to include strategies to strengthen health services to assure consistency in messages and practices between services and the community. This discussion should indicate how this would be done, with corresponding activities reflected in the training plan and budget. A more complete training plan would be useful that how many people from each cadre will be trained and in what.

In reviewing the proposed number of villages (375), active health committees (249), number of collaborating HSAs (72 with 10 senior), and number of Care Groups (257), clarify how the project is proposing to assure coverage of the full district, particularly those areas that are less active. It would be helpful to include more explanation of how the role of the HSAs will be maximized and supported.

Knowing that volunteer motivation has been a severe problem in Malawi since the fall of Banda, it would be helpful to include further discussion on the motivation and maintenance of the Care Group volunteers. There should be per diem costs for training in the budget, unless it is under volunteer training supplies.

Since previous studies show that distance and cost are major factors for non-use of modern health facilities, include a discussion of how referral will work if there is no transportation or other support.

WR's link with the CORE Group and their recognized lead with CS PVOs in Malawi could be enhanced. This is an opportunity for an expanded effort to become a more active leader in the country, potentially setting up an exchange program that allows the different in-country PVOs to set up site visits to see the different models, with a particular focus on the WR Care Group model.

The CDD intervention should include promotion of zinc supplements with the "new" ORS in the treatment of diarrhea. It should recognize the importance of integrating activities around water and sanitation and increasing awareness in the community about "point of use" disinfection.

HIV seems to be an afterthought to program strategies and is not well explained. There is VCT without access to PMTCT and/or ARVs.

The methodology for implementing PD/Hearth needs to be clarified and elaborated. Specific to the proposed Hearth intervention, the completion of two cycles in two years seems limited given the high level of malnutrition. Include a discussion of how the project proposes to broaden access to these activities. Clarify if WR is purposely limiting this activity to the most acute areas due to the 20% LOE attributed to nutrition. The program should recognize that PD/Hearth activities only target villages/communities where at least 30% of children are malnourished and where there are available local resources for the Hearth sessions. In addition, PD/Hearth should be implemented in the context of a broader, comprehensive nutrition program. A 20% LOE attributed to nutrition does not appear realistic given the intensive effort needed to implement PD/Hearth.

The application states that UNICEF has offered to work with WR and the district to ensure that the HSAs and Chitipa have drug kits in time for program implementation. This should be documented with a letter of support provided from UNICEF. Discuss any alternative options should UNICEF not be supportive of its commitment.

The SOL letter of support (without a date) mentions use of 17 key family practices which are not discussed in the program strategy. It is important to clarify the relationship between the program's technical approach, these 17 key family practices, and their relation to MoH policies and guidelines.

A direct reference to the well-known human resources crises/staff shortage in the modern health sector needs to be considered and addressed. Although using a large number of volunteers to run a community health intervention is low-cost, there is concern regarding sustainability because of possible attrition and/or waning motivation. The way the volunteers will be recruited, trained, and retained needs to be clarified. Issues around sustainability need to be more clearly addressed. It is recommended that WR consider applying the CSSA sustainability framework in development of this program.

PERFORMANCE MONITORING AND EVALUATION

Strengths

The proposed monitoring and evaluation system is well defined with clear and appropriate indicators, clear targets, and an emphasis on collection and use of data at the community level. The project proposes to use LQAS for routine monitoring to review progress on its impact indicators.

By involving caregivers in surveillance activities and discussing their findings during community and Care Group support meetings, the process both offers monitoring data and raises community awareness of health issues. WR proposes creative ideas to share results with the community. The dissemination strategy with program stakeholders includes church leaders and volunteers so as to maintain open communication with these partners and is a good approach.

The community level information system will complement and validate information already being collected by the MoH. It could provide the MoH with current data to report to senior management in the district, which could be very important for continued support.

An additional strength of the M&E system is the integration of personnel performance evaluation with other monitoring activities. This clearly sets expectations and holds staff accountable for their performance.

Baseline and evaluation studies are clearly outlined, appropriate, and budgeted. The baseline and identification of Rapid CATCH indicators will be very useful for on-going program assessments. The targeted sampling based on Care Groups within a health promoter's catchment area should provide useful insight for the program on a 6-month basis, a reasonable timeframe.

M&E functions are included in the job description for the Program Manager, based in Karonga. The proposal identifies the District Statistician as the link with the WR Project Manager.

Weaknesses

The proposed quarterly rapid assessments may prove burdensome and be too frequent to detect useful change given the impact nature of most of the indicators. While utilization data will only serve as a proxy for the indicators the project is seeking to measure, it might be more realistic to use utilization data to monitor progress frequently, and to decrease the LQAS measurements to bi-annually, or even less often. There are other activity monitoring or drug use data that could also serve as proxy monitoring tools in between the rapid assessments.

WR should consider integrating any existing MoH indicators and data in its M&E plan to create greater linkages between partners and to demonstrate the project's applicability and replicability for scaling-up.

The malaria treatment objective refers to treatment at a health facility. There will need to be an objective related to encouraging home case management and treatment in uncomplicated cases. There is a typographical error in the malaria indicator, "percent of pregnant women receiving IPT" (Annex F). The objective states that two doses of SP will be given while the indicator states one dose.

It may be useful to add an indicator to reflect linkages between health centers and their communities, since this is one of the sustainability elements.

The operations research on the welfare of orphans could potentially impede the other child health interventions or distract the work of the Program Manager. Since this might not be considered critical for this project, WR should consider moving it to the second half of the grant period, or to a separate setting.

MANAGEMENT PLAN

Strengths

WR is commended for recognizing the need to locate the support office in Karonga, although it adds cost and hassle to project management. Office space at the district hospital in Chitipa for some of the staff is an important acceptance by the MoH district team. Delegation of adequate authority to the Deputy Program Manager based in Chitipa (as indicated in the job descriptions and financial management plan) will be essential to the success of this structure.

There is sufficient staff to adequately support such a wide range and number of community volunteers. There is a good outline of the roles and responsibilities of key staff. The work plan is quite detailed and provides good information on the 32 health promoters and their routine work with volunteers and visits to the communities.

The incorporation of secunded HSA leaders into the Care Group support strategy is an innovative and positive move towards motivating and sustaining community level activities under government auspices.

Planned support for child survival from Headquarters is solid with well qualified staff. The budget allows for staff development in Headquarters as well as the field.

Weaknesses

This section would be strengthened with more elaboration of the HSA role and how they will be collaborating with and supported by the project promoters.

Management staff in the field will need access to financial information for decision making.

Since the WR drug revolving fund activities link with the UNICEF supported community drug kits coming to the district, the work plan should reflect this activity, eventually with dates.

COLLABORATION WITH USAID FIELD MISSIONS

Strengths

The application supports the Mission's priorities and interest of the health office. The key indicators identified by WR are tracked and reported on by the Mission. The Mission has been very actively engaged in furthering the partnership with WR in this location which currently has no Mission-supported partners. The Mission's letter of support indicates they are seeking bridge funding for this year in hopes that a future grant might be obtained.

Weaknesses

It will be important to align the program with the most recent version of the Mission's health SO and IR statements.

OVERVIEW COMMENTS

This is a well-written proposal for a coherent, well developed project that maximizes existing activities, resources, and partners. It targets one of the neediest areas in Malawi, with concrete interventions that address the highest causes of mortality and morbidity in children under five. A major strength is in the credibility and past work of WR in Malawi and in neighboring countries. WR shows outstanding understanding of the local context.

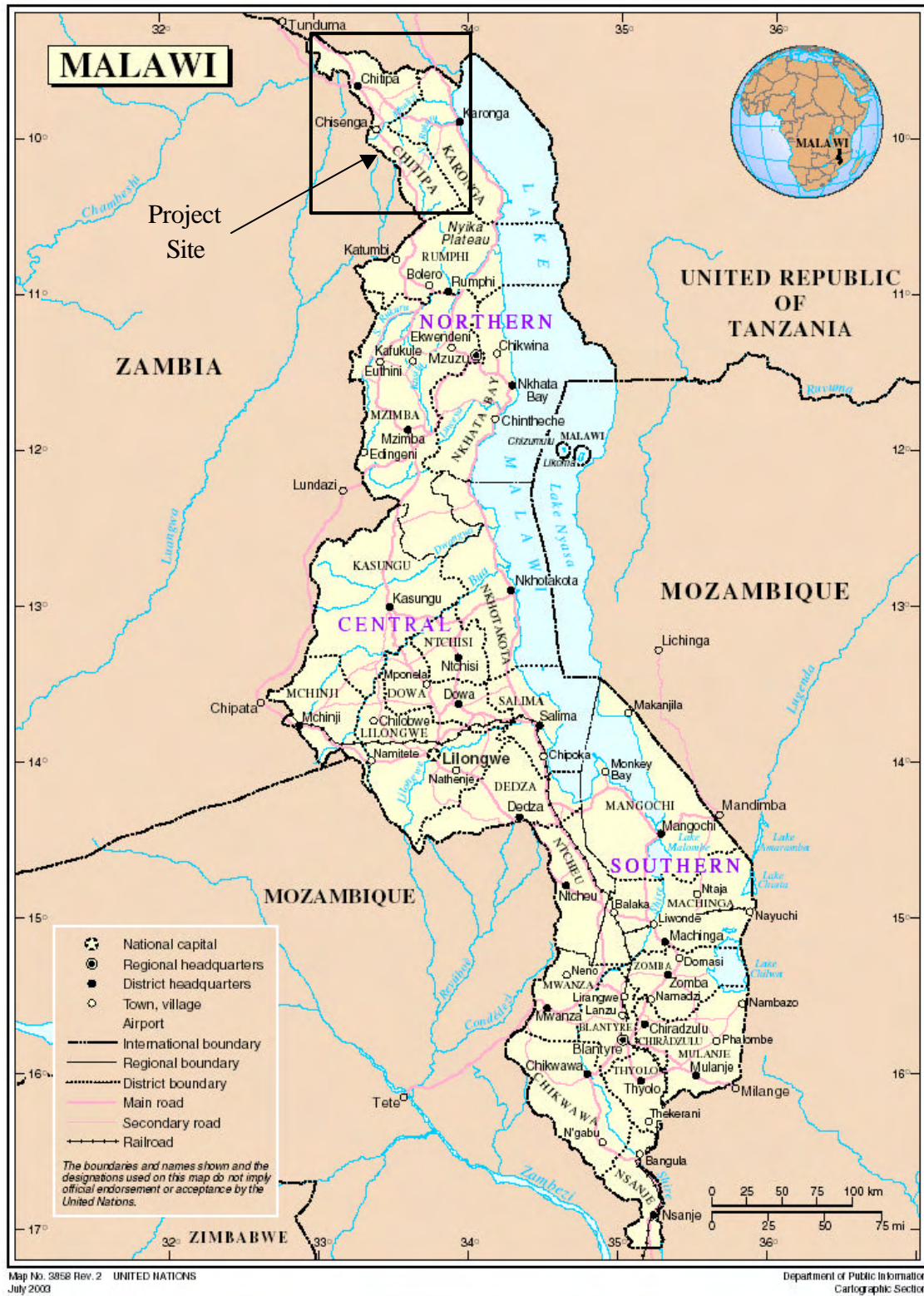
The proposal reflects a well thought out approach to community involvement and one that has a demonstrated success rate in Malawi and other countries around the world. The request from the MoH district health officer is a strong testament to the need for assistance at the community level. WR's awareness of other community level activities and their ability to link with other institutions such as UNICEF and Food Aid programs enhances their ability to be a success on the ground. The link with the Livingstonia Synod is an effective and credible partner in the target area.

The package of interventions, strategies, and objectives is carefully selected and well integrated both internally and with existing programs. It targets the essential behaviors for child health using globally accepted interventions. WR's Care Group approach, particularly as an intervention to address the problems of AIDS orphans, its expected partnerships, and the organization's significant experience both in child survival and in Malawi, add to the project's interest and viability.

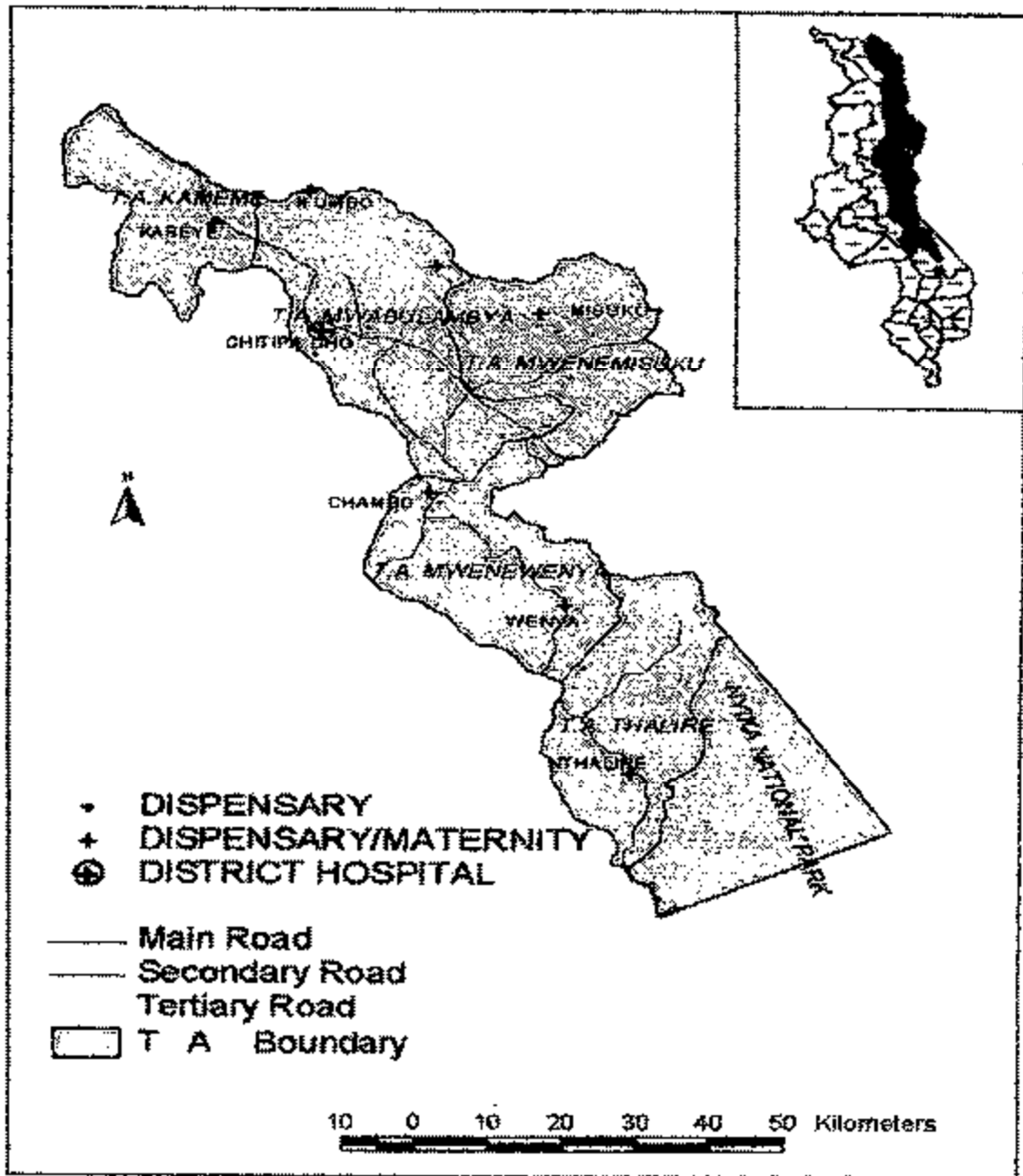
There could have been a stronger explanation of how the formal health services are to be strengthened, particularly in appropriate case management for malaria, pneumonia, and malnutrition.

There remains some concern how the large number of volunteers -- the backbone of the proposed intervention--will be recruited, trained, retained, and motivated. Their qualification should be specified. There needs to be a discussion of how sustainable a health care system is that is based on community volunteers in a resource-poor country where even the MoH has serious difficulties in delivering quality health care.

Map of the Tube Poka Project Site



DISTRIBUTION OF HEALTH FACILITIES, CHITIPA DISTRICT, MALAWI



BASELINE KNOWLEDGE, PRACTICE AND COVERAGE SURVEY

Baseline for World Relief Malawi
Tube Poka Child Survival Project, Chitipa District,
Northern Malawi

§

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Executive Summary

The World Relief Child Survival Program Director, together with several Ministry of Health and CCAP (Church of Central Africa Presbyterian) staff conducted a baseline Knowledge, Practice and Coverage (KPC) survey between 8 and 19 April 2005, during a “bridge” funding period from USAID Mission to Malawi, after the conclusion of a CSP and in anticipation of start up activities for the Chitipa CSP in October, 2005. The survey was designed to assess the knowledge and practices of mothers of children 0-23 months concerning common childhood illnesses, specifically, control of diarrhea diseases, malaria control, pneumonia case management, infant and young child feeding, immunization status of mothers and children, growth monitoring, birth spacing and HIV/AIDS. The current Child Survival Program covers the entire Chitipa District, with HC catchment areas including Wenya, Misuku, Nthalire, Chitipa Central Chambo, Ifumbo, Mwabulambia and Kaseye.

The 30 Cluster survey methodology was used for data gathering. The questionnaire developed by CSTS+ was adapted to fit the local context. The questionnaire was translated into Chitumbuka, the predominant local language in Chitipa, and translated back into English to check for accuracy. The Chitumbuka questionnaire was then pilot tested before it was used for data collection. Because of updates to the Rapid Catch Questions and KPC requirements, a follow up survey was conducted April 2006 to include the updated information.

Major survey findings:

Education: 37% mothers are illiterate and 21% had post-primary education

Malaria: 18% of children under two with fever received treatment within 24h of onset of symptoms; 41% of under-twos slept under bed nets, while 37% of mothers of children aged 0-23months slept under bed nets.

Exclusive Breastfeeding: 40% of children <6m were exclusively breastfed

Immunizations: 55% of children 12-23m received measles vaccination, 69% of children 12-23m were fully immunized, 64% of mothers received at least two TT doses in their last pregnancy

Hand Washing: 35.1% of mothers of children 0-23months report that they wash their hands before food preparation, before feeding child, after defecation and after cleaning child's faeces

Growth Monitoring: 30% of children 0-23m were under weight-for-age

Illness recognition and Care seeking: 85% of children had an illness during the 2 weeks preceding the survey; 71.2% of mothers knew at least two danger signs of illness warranting immediate treatment at HF

HIV/AIDS: 67.5% of mothers with children under the age of two knew at least two ways for reducing the likelihood of HIV transmission.

Child Spacing: 39.5% of children 0-23months were born at least 24 months after the last surviving child

Background

Malawi is one of the world's poorest countries, ranking 165/177 on the Human Development Index, with a GNP of US \$210 per capitaⁱ. About 65% of Malawi's population lives in poverty, and Malawi has one of the most unequal distributions of wealth in the worldⁱⁱ. Reliance on rain-dependent primary crops such as tobacco, maize, groundnuts, and beans leaves the economy vulnerable to droughts and long periods of low rainfall. Malawi's health indicators are among the worst in the world, with distinct regional variations.

Malawi is divided into three regions - northern, central and southern, and twenty-eight districts. Chitipa is the northernmost district in Malawi, bordered by Tanzania and Zambia in the north and southwest and the districts Rumphi and Karonga in the south and northeast. Chitipa has a land surface area of 4,288 square kilometres and is about 400 km away from the Northern Regional Headquarters of Mzuzu. Chitipa has a mountainous terrain - the beautiful Misuku Hills in the north, and the Nthali Corridor in the south. The mountainous terrain, geographic isolation, and poverty contribute to increased vulnerability of women and children to common diseases and illnesses.

The population of Chitipa is primarily rural, with an estimated total population of 174,786 people scattered over the mountains in 475 villages. According to a census conducted by the project in January 2006, there are 32,025 children under age five (18% of total population) and 40,201 women of reproductive age (42% of total population). These calculations are similar to national estimates in the 2004 DHS, where children under five make up 18.4% of the total rural population and women 15-49 equal 39.1% of the same.

Chitipa's inhabitants are diverse, with about 15 ethnic groups and almost as many languages. Chitipa is predominantly Christian (96%), with the highest illiteracy rate (33%) of the six northern districtsⁱⁱⁱ. Differential household food share in favor of males puts mothers and female children at increased risk of malnutrition, while malaria, pneumonia and diarrhea remain public health threats to women and children in Chitipa. Disease burden attributable to malaria is over 36%, and case fatality rate is 50% higher than the national average^{iv}. Over 50% of households in Chitipa have to walk more than 30 minutes to a safe water source. The poor road infrastructure hampers potential areas of development in the district, including marketing and tourism. The situation has been exacerbated by lack of leadership focus on enhancing the quality of basic structures over the past decade. There is currently no public transport system operating in Chitipa.

Poverty, human deprivation and suffering are aggravated by the high HIV/AIDS prevalence in Malawi. For many children and families, the onset of

AIDS signals the beginning of a transition from poverty to complete destitution. The proportion of orphans in Chitipa increased from 34% to 52% between 1997 and 2000, with an estimated 49% due to HIV/AIDS. By July 2004, the orphan toll had reached 3,412^v.

Project Goals

The program's overall goal is to reduce disease burden in U5 children and women of reproductive age (WRA), by establishing an effective community-based system for implementing C-IMCI using the Care Group (CG) Model.

Project Objectives

- 1) Strengthen the capacity of the health system to improve quality and coverage of C-IMCI services through training, drug management, supervision and establishing effective information systems
- 2) Develop sustainable community based mechanisms to improve prevention and care seeking practices for C-IMCI
- 3) Improving coverage and utilization rates of malaria control strategies according to Roll Back Malaria guidelines.

Table 1: Intervention Mix and Level of effort

INTERVENTION MIX	LEVEL OF EFFORT
Malaria Prevention and Case Management	30%
Nutrition	20%
Control of Diarrheal Diseases	20%
Pneumonia Case Management	10%
HIV/AIDS Prevention	5%
Immunization	15%

KPC Survey Design

Methods of identifying partners to engage in KPC Survey

Several consultative meetings were held with stakeholders to discuss World Relief Malawi's vision and intentions to engage in transformational development in Chitipa District. World Relief staff explained in detail the need to conduct a survey to identify levels of health indicators that would become the basis for monitoring Child Survival interventions. The Ministry of Health District Hospital in Chitipa played a great role as a major partner in supporting this activity with personnel, fuel and transportation while the Ministry of Gender, Community Services and Social Welfare and World Vision Malawi provided personnel as well.

Objective of the Survey

The main objective of the survey was to determine the level of different indicators at baseline to guide program design and implementation, and provide a benchmark for monitoring program performance. Subsequent survey results would then be compared with the baseline survey to assess program impact.

Survey Sites

The baseline survey was conducted in the villages of five Traditional Authorities (or Chiefs): Senior Chief Kameme, Senior Chief Mwabulambia, Chief MweneMisuku, Chief MweneWenya and Chief Nthalire in the sampled villages (taken as clusters).

Time and duration of the survey

Data collection for the survey was conducted from 8th to 19th April, 2005.

Methods

Sampling unit:

For the purpose of the survey, the smallest basic sampling unit was the household.

A household was defined as a group of people living in the same house and who shared the same pot the previous day. If wives in polygamous homes lived in the same area but cooked separately they were considered separate households (See selection of household). Households with women who had children aged 0-23 months were selected for the survey.

Study population:

The study population included the inhabitants of the five areas mentioned above. The selected subjects for the study were women of reproductive age (WRA) (aged 15-49) and children under 2 years living in the same area.

Sampling design:

Before discussing the features of the sampling design, it is necessary to define a few basic concepts related to samples and sampling. A sample was chosen to represent a large universe called the target population. This population consisted of individuals called “members” who were survey respondents.

Sample size

The sample size was determined using the CSTS+ KPC Module - 2 stage 30x10 clusters sampling method for surveys.

Thirty clusters were randomly selected from a list of all the villages in Chitipa, taking into account the differences in population size of the villages (Proportional Population Cluster Sampling method). For each cluster, interviews were conducted with 10 households having children under the age of two years. (Specifics on household selection are addressed later.)

The sample size was calculated using the formula below.

$$N = \frac{Z^2(1-P)P}{E^2}$$

N= Sample size

Z=1.96 (for a confidence interval of 95%)

P= Known prevalence

E=% within=±0.05

Interview

The enumerators conducted household interviews and the supervisors conducted the mortality interviews.

The questionnaire was pre-tested before applying it to the actual survey.

Survey Team Recruitment and Training:

To handle the survey effectively, 3 teams were mobilized. The composition of the entire survey team was 12 enumerators, 3 supervisors, 3 drivers, 1 data entry clerk and 1 survey coordinator, for a total number of 20 members. The group of enumerators included nurses, customer service facilitators, environmental health assistants and World Relief field staff.

It was advisable to recruit local staff to overcome language barriers, and trained health staff so that they could explain some of the issues in the questionnaire to the interviewees.

The two-day training started on 8th April and finished on the 9th of April 2005. Following the training, the questionnaire was pre-tested and necessary modifications were made.

Training of the field enumerators:

Before the actual survey, comprehensive training was provided to the enumerators and the entire survey team was trained for the purpose of achieving the objectives stated below.

Training Objectives:

The main aims of the training:

- To enable the survey team understand the reasons behind the implementation of the Child Survival Interventions (through BCC)
- To discuss the survey design and methodology
- To impart data collection techniques for conducting the survey
- To train data entry staff
- To build capacity of the survey team

The topics for training included:

- Introduction to World Relief Malawi and the Child Survival Project approach
- Introduction to survey methodology
- Village Entry Process
- Understanding the questionnaire

Selecting a household:

Upon arriving in a village, the village headman was asked to identify a place considered close to the central point of the village. At the central site, the village headman spun either a bottle or a pen. The survey team started in the direction of the bottle (open end) or pen (pointed end) to the first house. If the object pointed in the direction where there were no houses, the procedure would be repeated until there were houses in that direction.

The interview started at the nearest household and proceeded to the next one in the same direction until the required number of households per cluster was met. If, due to proportional population cluster sampling technique, more than one cluster was required from the same village, the object was spun independently for each team.

In cases where the chosen direction had less than the required sample the object would be re-spun to change direction at the farthest household and the team proceeded in that direction until the total required sample in that cluster was met.

Data Entry and Analysis:

EPI-INFO version 6.04 was used for data entry and analysis.

Results and Discussion

Out of a total of 370 eligible households that were identified, six were discarded due to incomplete information, leaving 364 that formed the basis for analysis.

Summary of KPC Survey Findings

RAPID CATCH INDICATOR	%
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	29.9%
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	39.5%
Percentage of children age 0-23 months whose births were attended by skilled health personnel	55.2%
Percentage of mothers with children age 0-23 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	64%
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	40%
Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	39.6%
Percentage of children age 12-23 months who are fully vaccinated (against the 5 vaccine-preventable diseases) before the first birthday	68.8%
Percentage of children age 12-23 months who received a measles vaccine	55.4%
Percentage of children age 0-23 months who slept under an insecticide treated net (in malaria risk areas) the previous night	41%
Percentage of mothers with children age 0-23 months cite at least 2 known ways of reducing the risk of HIV infection**	67.5%
Percentage of mothers with children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	35.1%
Percentage of mothers of children age 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment	71.2%
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	3.8%
NON- RAPID CATCH INDICATORS	
Percentage of children age 0-23 months with fever who were treated within 24h of onset of symptoms	17.5%
Percentage of children age 6-23 months who received 2 doses of vitamin A	53.8%
Percentage of mothers with children age 0-23 months who slept under a bed net (in malaria risk areas) the previous night	37%

Description of Respondents

All survey respondents were married and aged between 15 and 49 years; with 35% aged 20-24 years. Twelve percent of respondents were younger than 20 years, showing that early marriage is quite common in Chitipa. Figure 1 below illustrates the respondents' age distribution. 36.6% of respondents were illiterate, 6.6% (24/364) of these had no schooling at all. Majority did not proceed beyond standard eight grade (Figure 2), and of every three girls who got to grade six in primary school, only one went on to secondary school; and only one respondent had college education. Survey findings reveal that 73.3% of the respondents draw their drinking water from protected sources as compared to 26.7% who use water from unprotected sources. About half (53.3%) have access to bore holes. Over 95% of respondents use traditional pit latrine (21.3% shared with their neighbors) while 4.2% dispose human waste in the bush. This is a great achievement for the district and requires reinforcement and sustained promotion.

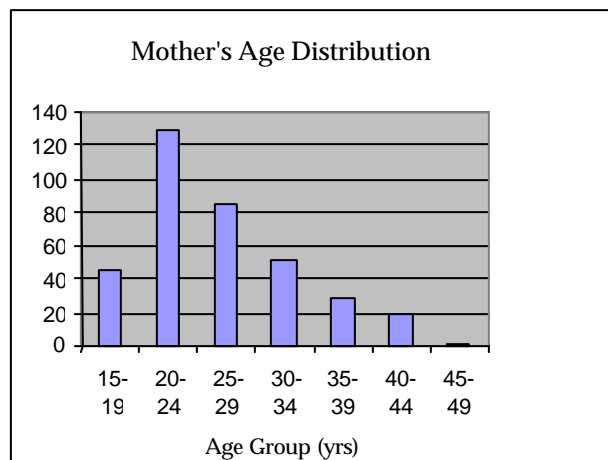


Fig 1: Age Distribution of mothers with 0-23 m old children

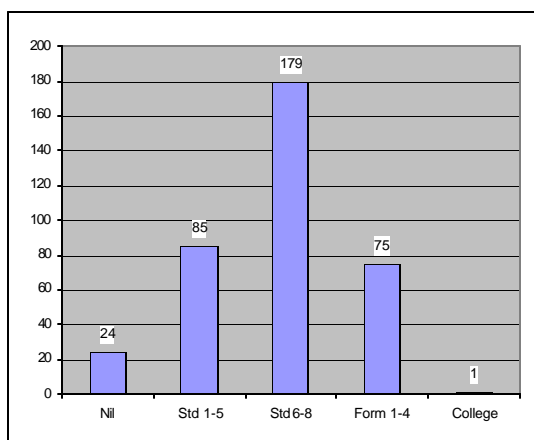


Figure 2: Mothers' Highest Educational Attainment

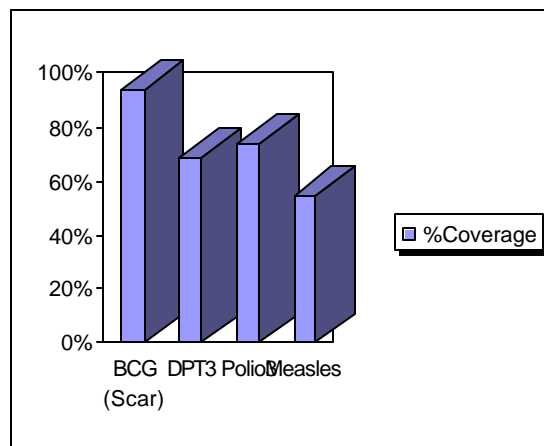


Fig 3: Immunization Coverage for 12-23m old children.

Breastfeeding and Nutrition

Questions on infant and young child feeding practices were all based on recall memory. Ninety eight percent (355/362) of mothers indicated that they breast fed their youngest 0-23 month old child, but only 45.1% started breastfeeding within the first hour of delivery. Only 40% (20/50) of mothers with babies aged 0-6m were breastfeeding exclusively, though 95.2% of the mothers were still breast feeding at the time of the survey.

The survey was conducted when most families had adequate food and different results are expected for the 'hungry months'. The survey also established that 39.6% of the mothers gave mashed food to their children who were older than six months of age only once in the previous day.

Growth Monitoring

Eighty-eight percent of mothers had under-five health cards, while 7.2% had records in notebooks or paper, and 81% of the children had been weighed during Growth Monitoring sessions at least once in the four months preceding the survey. Mothers were willing to have their children weighed (99.2%) during the survey, and thirty percent (29.9%) of the children weighed were underweight (<-2SD from the median of 8.0Kg, weight-for-age according to WHO/NCHS reference population), with equal sex distribution.

Child Immunization and Vitamin A supplementation

Child immunization coverage rates rose from 58% (1999) to 100% (2002) in Chitipa, with UNICEF support. However, this situation has been adversely affected by transitions and lack of adequate logistical support, the result of which is a sharp decline in immunization coverage rates (69% of children 12-23m fully

immunized, 55.4% received measles vaccine at 9m), constituting a major threat to child survival in Chitipa. A child who had had his/her BCG with a visible scar and had attained the first birthday or was aged between 9-11 months and had received DPT3, measles and OPV3 was defined as fully protected against immunizable diseases. 53.8% of children six months and older had received at least two doses of Vitamin A (by card). See figure 4 for illustration on child immunization coverage.

Malaria Control

Malaria continues to claim many lives in Malawi and Chitipa especially children under five years of age and pregnant women. The current preventive and case management systems in Chitipa do not provide optimal services for the most vulnerable groups in the community. Mosquito net (treated and untreated) coverage of 44.2% is inadequate to produce significant reduction in malaria morbidity and mortality in Chitipa.

A total of 59.6% (217/364) of mothers reported fever in their children 0-23m in the two weeks preceding the survey, but only 17.5% received treatment at a HF within 24h of onset of the fever. Three out of four mothers (76.2%) sought treatment within 1-3days of the onset of symptoms.

Pneumonia Case Management

Forty-two percent of mothers reported fever and rapid breathing in their children 0-23m in the two weeks preceding the survey, but only 20.9% received treatment at a HF within 24h of onset of the fever.

Control of Diarrhea Disease and Handwashing Practices

Of the 0-23m old children who had diarrhea in the two weeks preceding the KPC survey (30.5%), only 3.8% and 8.3% respectively, were offered increased foods and increased fluids. Thirty-five percent of mothers indicated that they washed their hands with soap before feeding children, after defecation, after cleaning child's feces and before food preparation.

Integrated Management of Childhood Illnesses

Eighty-five percent (311/364) of children 0-23m were reported to have been ill in the two weeks preceding the survey, and 9.6% had fever at the time of the survey. This indicates that many children in Chitipa carry high morbidity risks from common childhood illnesses.

Seventy-two percent of respondents knew at least two danger signs that would prompt them to seek immediate health facility care, many identified bloody diarrhea, fever, convulsions, vomiting, loss of appetite and pallor as signs that would warrant immediate HF care.

HIV/AIDS and STI Prevention

Knowledge of HIV/AIDS among adults in Malawi is near universal – 95%^{vi}. KPC survey findings in Chitipa reveal a similar rate of 95.8% among survey respondents. Thirty-five percent knew just one method of preventing HIV/AIDS infection while 67.5% knew two or more ways to reduce the risk of HIV transmission. Methods identified include reducing the number of partners, using own razors, using a condom during sexual intercourse, having one sexual partner, avoiding exposure to blood products, and not using contaminated sharp instruments. Some women indicated that knowledge of one's HIV status is vital to controlling the spread of this scourge. 89.8% indicated a willingness to get tested for HIV/AIDS. Eighty-nine percent of respondents are aware that HIV can be transmitted from mother to child during pregnancy (39.6%), delivery of mother-to-child (27.5%) and through breast milk (30.6%).

30.6% of women reported using condoms during the last sexual act with their spouses (corresponding to the proportion that use condoms for family planning purposes).

Child Spacing

Chitipa district has a very versatile community-based Population Services Program that provides door-to-door family planning (FP) services to couples through Community-based Distribution Agents (CBDAs). Majority (94.4%) of the women knew where to access FP services, and 83.3% did so from CBDAs while only 8.3% did from health facilities and 2% used traditional healers. Contraceptive methods reported by respondents are condoms (31.8%), pills (16%), *Depo Provera* (25.5%) and other methods (5.3%) including withdrawal, Bilateral Tubal Ligation, Norplant, and traditional methods.

Other sources of FP education and/or services include Banja L Mtsogolo (an indigenous organization that provides the full range of FP services, including tubal ligation and education for clients), older women who promote traditional methods of birth control, and friends.

The 2006 Survey findings revealed that 39.5% of 0-23 months old children were born at least 24 months after the surviving child, and mean birth interval was 30months.

At the time the KPC survey was conducted, 4.9% of the mothers were pregnant and 36.4% of the mothers wanted another baby in the next two years. This is

consistent with the 2006 survey finding of 39.5% reporting birth intervals of 24 months between the 0-23 month old child and the surviving older sibling.

Maternal and Newborn Care

Tetanus Toxoid Vaccine (TTV): Women of reproductive age are required to receive five doses of TTV in their reproductive life to ensure full protection against tetanus, a deadly disease. Both recall and card were used to establish coverage of TTV in the district. 76.7% of respondents received at least one dose of TTV during the pregnancy of their 0-23 month old child, while 64% received at least 2 doses. However, only 23% continued to complete the recommended schedule after delivery. Only 35% of mothers knew that TTV protects against tetanus, another 35% associated the vaccine with various roles such as protection against other diseases, while the remaining had no knowledge of its purpose at all.

Antenatal Care: 96.4% of respondents indicated that they had accessed antenatal care (ANC) services during the pregnancy of their 0-23 month old child. 76.4% of the mothers had antenatal cards and most (96.4%) attended ANC provided by the District MOH while others received ANC at church supported health facilities. A small proportion (2.0%) attended TBA clinics. Figure 4 below illustrates the frequency of ANC visits by pregnant mothers, with a mean of 3 visits throughout pregnancy, though four visits are recommended for optimal pregnancy outcome. Seventy-five (74.7%) of mothers reported that they would seek urgent medical attention from the nearest HF if they had malaria, anemia, severe headaches, vaginal bleeding, hypertension and abdominal pains during pregnancy.

Place of Delivery and Post-natal Care: According to KPC survey findings, 55% of deliveries occur at HF, 27% at home, 16% with TBAs and 2% on the way to HF, though 14.5% of HF deliveries are referrals from TBAs (both trained and untrained). It's good to note that irrespective of place of delivery, 96% of mothers reported that a clean razor was used to cut their baby's umbilical cord. Delivery attended by unskilled/untrained personnel carries great risk to the mother and the newborn. Though over 50% of the respondents delivered at a HF, almost two-thirds (66.5%) of respondents were not examined soon after delivery to detect potential complications. Home deliveries continue to pose a great challenge in the district as mothers miss the initial child vaccination and post-partum maternal examination and vitamin A supplementation opportunities. Only 34% of mothers reported receiving Vitamin A postpartum. About one-third of newborns were separated from their mothers soon after birth for about 24 hours, the period when breast feeding and mother-child bonding is best initiated.

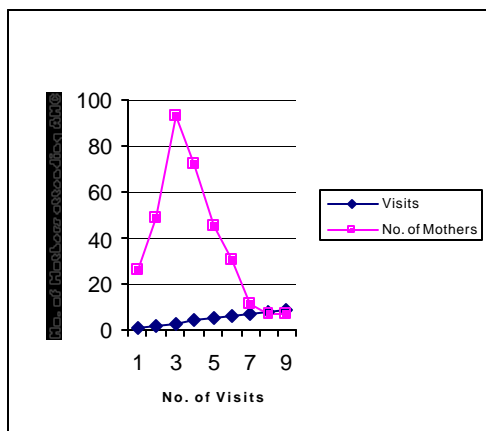


Fig 4: ANC visits in pregnancy

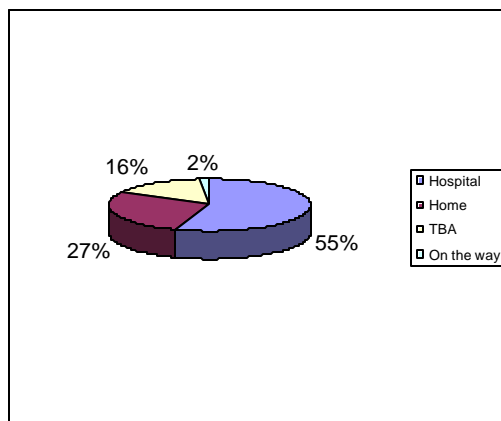


Fig 5: Place of Delivery

IPT and Iron Supplementation in Pregnancy

SP (or Fansidar) and iron play a major role in controlling malaria and malaria-related complications in a mother and her growing fetus. The survey findings indicate that 58.2% (by card) of the mothers attending ANC received at least two doses of SP during pregnancy (according to MOH National Policy) to protect them from severe forms of malaria. There is good compliance with iron supplementation as indicated by the 85.1% of mothers who reported taking iron supplements daily. World Vision's nutrition project has assisted in maintaining desirable practices among families of the target communities.

Annex A: Chitipa KPC 2005 Survey Participants:

Responsibility	Member Name	Affiliation
Enumerators:	Wild Mbeye Kingsley Fweta John Mbene Tamandani Juma Saulos Kanyinji Phillip Chawinga Aurther Mpumulo Joseph Chavula Rodney Nyirenda Forward Chilanga Thomas Nkhonjera Henry Mshanga	Misuku Health Centre Chisenga Health Centre Chitipa District Hospital Chitipa District Hospital Nthalire Health Centre World Vision World Vision World Relief Luwuchi CCAP Mzuzu – Chibabvi CCAP Misuku – Katobo CCAP District Social Welfare Office
Supervisors:	McLeod Majonga Esther Chirambo RE Mkandawire	Chitipa District Hospital Embangweni Hospital Rumphi District Hospital
Survey Coordinator:	Victor Kabaghe	World Relief
Drivers:	Isaac Munthali Vertex Siyame	World Relief Chitipa District Hospital
Data Entry Clerks:	Maria Mpesi	World Relief

ANNEX B: CHITIPA DISTRICT SAMPLED CLUSTERS

Chitipa South (Nthalire)

No.	Name of Cluster	Number of Households
1	Chinyombe	10
2	Kamilang'ombe	10
3	Mambwe	10
4	Msangawale I	10
5	Mweneluwembe	10
6	Wavikaza	10
Wenya		
1	Malawa	10
2	Jembia (Mulumbe)	7
3	Namapanji	20

Chitipa North

No.	Name of Cluster	Number of Households
1.	Ipenza IV	17
2	Amon Kameme II	10
3	Phillip Muyimbo II	10
4	Kasisi Nyondo III	10
5	Yoramu Vunduvundu	10
6	Mboya	10
7	MweIchinga	20

Chitipa East (Misuku)

No.	Name of Cluster	Number of Households
1.	Mphonda II (Mtogha)	10
2.	Mwakayera (Sokola)	20
3.	Mwandisi (Misuku Centre)	20
4.	Yoramu Kangele	10
5.	Yeniyeni Musukwa	10

Chitipa Central

No.	Name of Cluster	Number of Households
1.	John Nyondo	10
2.	Katutula	20
3.	Simon Ng'ambi	10
4.	Zambwe 3	10
5.	Robert Ng'ambi (Kanyenjere)	10
6.	Nkhuweme Ng'ambi (Ikumbilo)	10
7	Yona Nyondo	10
8	Munyera	10
9	Chilupula	10

ⁱ Human Development Report 2005

ⁱⁱ Malawi Poverty Assessment 2005

ⁱⁱⁱ Chitipa Socioeconomic Profile 2002

Follow up Survey, April 2006

Information gathering for three Rapid Catch indicators had to be repeated in April 2006 to ensure conformance with recommended RC indicator reporting.

The three indicators are:

- Child spacing – Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child
- Exclusive breastfeeding – Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours
- Hand washing – Percentage of mothers with children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Data collection was conducted as part of scheduled local rapid assessment to assess level of household knowledge on malaria intervention that has been introduced by promoters. The survey team comprised MOH and CSP staff, and was led by the Program Director who has experience in survey methodology from previous CS program. Survey questionnaire was developed and translated into Chitumbuka and translate back into English to ensure that questions will convey desired messages accurately. The questionnaire was pre-tested before it was adapted for use in the survey.

Survey sample size was calculated using standard formula (see KPC report), but a total of 329 households (rather than calculated 378) were sampled because activities were stalled by heavy rains and transport difficulties.

A systematic multi-stage sampling method was used, with clustering down in four stages. All supervision areas were included in the survey, and names of all the promoters in each supervision area were written on individual sheets of paper which were folded and dropped in boxes. Drawing for each supervision area was done independently, with one supervisor from a different area picking a sheet of paper at random to determine which promoter will participate in the sampling. This process was repeated till three promoters had been selected per supervision area. Each selected promoter then provided a list of all the Care Groups under his supervision from which three were selected following the same steps that were used for promoters. For each Care Group selected, the list of all volunteers in each group was created and three volunteers per Care Group were again randomly selected. All households with children 0-23months from each selected volunteer were written on individual pieces of paper from where two households per volunteer were drawn for sampling.

Data entry and analysis was done with Epi-info 6, and results have been incorporated into the relevant sections of the KPC report.

KPC QUESTIONNAIRE

World Relief Malawi Chitipa District Child Survival Program, April 2005

INTERVIEW DATE ____dd/____mm/____yy **Unit No. ##** ____

Village _____ **Enumerator** _____

GENERAL QUESTIONS

Q1. How old are you? ____years

Q2. What year were you born? _____

Q3. How many years of schooling did you have? ____years

Q4. How old is (name of child)? _____ months

Q5. Is (name of child) your biological child? Y__ N__

If More Than One Child Is Under Five Go To Question 7

Q6a. Child's Name. _____ **Q6b.** Sex M/F **Q6c. DOB** __dd/__mm/__yy

More Than One Child Under Five

Q7a. First Child's Name _____ **Q7b. Sex** M/F **Q7c. DOB** __dd/__mm/__yy

Q7d. Second Child's Name _____ **Q7e. Sex** M/F **Q7f. DOB** __dd/__mm/__yy

Q7g. Third Child's Name _____ **Q7h. Sex** M/F **Q7i. DOB** __dd/__mm/__yy

[THE REST OF THE QUESTIONS ARE RELATED TO THE YOUNGEST CHILD ABOVE OR THE MOTHER OF THE CHILD]

GROWTH MONITORING AND IMMUNIZATION

Q8. May I weigh and measure (name of child)? Y___ /N___

Q9. Record weight ___ Kg

Q10. Do you have a Growth Monitoring Card for (name of child)? Y___ /N___

Q11. If yes may I see it please?

Q12. Was (name of child) weighed in the last 4 months Y___ /N___

Q13a. Does (name of child) have a Vaccination record? Y___ /N___

Q13b. If 'yes' may I see it please?

**Q14. RECORD INFORMATION EXACTLY AS IT APPEARS ON (NAME'S)
VACCINATION CARD.**

BCG ___dd/___mm/___yy
Polio 0 ___dd/___mm/___yy
Polio 1 ___dd/___mm/___yy
Polio 2 ___dd/___mm/___yy
Polio 3 ___dd/___mm/___yy
DPT 1 ___dd/___mm/___yy
DPT 2 ___dd/___mm/___yy
DPT 3 ___dd/___mm/___yy
Measles ___dd/___mm/___yy
Fully immunized Y___ /N___

Q15a. Iron date1 ___dd/___mm/___yy AGE1 __ months
Iron date2 ___dd/___mm/___yy AGE2 __ months
Iron date3 ___dd/___mm/___yy AGE3 __ month

Q15b. Vit. A date1 ___dd/___mm/___yy AGE1 __ months
Vit. A date2 ___dd/___mm/___yy AGE2 __ months
Vit. A date3 ___dd/___mm/___yy AGE3 __ months

Q16a. How often were iron tablets given?

Q16b. Has your child ever received iron tablets weekly? Y___ /N___

MATERNAL AND NEWBORN CARE

Q17a. Did you see anyone for prenatal care when you were pregnant with (name of child)? Y___ /N___

Q17b. If yes whom did you see?

Q18. How many times did you see someone for care when you were pregnant with (name of child)? _ _ times

Q19a. Do you have a maternal health card for your pregnancy? Y___ /N___

Q19b. If yes can I have a look at it? Look at the card and record the number of prenatal visits.

Q20. When did you start prenatal care?

A. The first 3 months

B. The second 3 months

C. The third 3 months

Q21a. Did you receive or buy any iron tablets when you were pregnant with (name of child)? Y___ /N___

Q21b. If yes, how many days did you take the iron tablets?

<60__ >60__ don't know__

Q22a. Did you receive or buy any SP tablets when you were pregnant with (name of child)? Y___ /N___

Q22b. If yes, how many times did you receive SP when you were pregnant with (name of child)? # of SP Doses _ _

Q23 While you were pregnant with (name of child) did you receive any vaccine? Y_/N___

Q24. If yes how many times did you receive the vaccinations? __ __ times

Q25a. Do you have a place where the vaccinations you received during your pregnancy with (name of child)? Y___ N___

Q25b. If yes, can I see it? Record # TT vaccinations as recorded in card

TTV1 __dd/__mm/__yy

TTV2 __dd/__mm/__yy

TTV3 __dd/__mm/__yy

TTV4 __dd/__mm/__yy

TTV5 __dd/__mm/__yy

Q26. What was the vaccination for? Record all responses (do not prompt).

Q27. Where did you deliver (name of child)?

- a. Health Facility
- b. Home
- c. Traditional birth attendant
- d. Church
- e. Other, specify _____

Q28a. Who assisted you with (name of child) the delivery?

- a. Doctor
- b. Nurse/midwife
- c. Auxiliary midwife
- d. Traditional birth attendant
- e. Community health worker
- f. Family member _____
(SPECIFY RELATIONSHIP TO RESPONDENT)
- g. Other _____
(SPECIFY)
- h. Herself

Q28b. What instrument was used to cut the cord? _____

Q28c. Did you provide your own instrument for cutting the cord? Y___ N___

Q29. Where was (name of child) put immediately after birth? Record all responses _____

Q30a. After (name of child) was born, did anyone test you? Y___ N___

Q30b. If yes, who checked on your health at that time? Record all mentioned.

Q31. How many days or weeks after delivery did the first check take place? ___ __

Q32. In the first two months after delivery, did you receive a Vitamin A capsule like this? Y___ N___

Q33a. What are the signs of illness in pregnancy that would indicate you need immediate treatment? Record all mentioned.

Q33b. What steps will you take if you were ill during pregnancy? Record all mentioned.

Q34a. What are the signs of illness during labor/delivery that would indicate you need immediate treatment? Record all mentioned.

Q34b. What steps will you take? Record all mentioned.

Q35a. What are the signs of illness after delivery that would indicate you need immediate treatment? Record all mentioned.

Q35b. What steps will you take? Record all mentioned.

FAMILY PLANNING

Q36a. Do you know where you can obtain a method of child spacing/Family Planning? Y__ / N__

Q36b. If yes, ask where is that? Record all mentioned
A. CBDA B. Health facility C. TBA D. Traditional Healer
E. Other (specify) _____

Q37a. Are you currently pregnant? Y___ /N___

Q37b. If no, do you want to have another child in the next two years?
A Yes___ B No___ C Don't know___

Q37c. If you don't want a child till next tow years, are you currently doing something or using any method to delay/avoid getting pregnant? Y/N

Q37d. If using FP, what method?
A. condom, B. Pills C. Injection D. Withdrawal E. Abstinence
F. Traditional methods G. Other, specify_____

BREASTFEEDING AND NUTRITION

Q38. Did you ever breast feed (name)? Y__ /N__

Q39. How long after birth did you first put (name) to the breast?
A. immediately/within 1st hour after delivery
B. After 1st hour
C. don't remember

Q40. Are you breastfeeding (name) now? Y/N

Types of Liquids and Foods That (Name) Consumed Yesterday during the Day or Night

Q41. What did (name) have yesterday?
Breast milk Y__ /N__
Plain water Y__ /N__
Other liquids Y__ /N__
Mashed, pureed, solid, semisolid Y__ /N__
Anything else Y__ /N__ (if yes, specify)_____

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)

Q42. What are the signs of illness that would indicate your child needs immediate treatment? Do not prompt. Record all mentioned.

Signs of illness

Signsick1 _____

Signsick2 _____

Signsick3 _____

Signsick4 _____

Signsick5 _____

Signsick6 _____

Signsick7 _____

Signsick8 _____

Signsick9 _____

Signsick10 _____

Q43a. Was (name of child) sick in the last two week? Y__ / N__

Q43b. When (name of child) was sick what signs did h/she experience?

Do not prompt. Record all mentioned.

Signs experienced

Recentsick1 _____

Recentsick2 _____

Recentsick3 _____

Recentsick4 _____

Recentsick5 _____

Recentsick6 _____

Recentsick7 _____

Recentsick8 _____

Recentsick9 _____

Recentsick10 _____

Q44. When (name of child) was sick, did s/he drink?

A. Less than usual B. Same amount C. more than usual?

Q45. When (name of child) was sick, did s/he eat?

A. Less than usual B. Same amount C. more than usual?

MALARIA

Q46. Has (name of child) been ill with fever in the last two weeks? Y__ / N__

If no, go to Q52.

Q47. If yes, was (name of child) taken to a healthy facility? Y__ / N__

If no, go to Q50.

Q48. If yes, how long after you noticed fever was (name of child) taken to a

healthy facility?

A. Same day B. Next day C. Two days D. Three or more days

Q49. If taken to a health facility, was (name of child) treated with any medicine(s) before going to the H/facility? Y__ / N__

Q50. Which medicines were given to (name) ? Record all mentioned

Medicine A. _____

Medicine B. _____

Medicine C. _____

Medicine D. _____

Medicine E. _____

Q51. From where did you get the medications?

A. Health Facility B. Drug seller C. Friend D. Other (specify) _____

Q52. . Do you have any bed nets in your house? Y__ / N__

If no, go to Q58

Q53. Who slept under a bed net last night?

A. Child. B. Mother C. Other (specify) _____

Q54. Was the bed net ever dipped in a liquid to repel mosquitoes or bugs? Y/N

If no, go to Q56

Q55. How long ago was the bed net dipped?

A. Less than 1month B. 1 to 6 months C. 6 to 12 months

D. More than 12 months

Q56. Have you or someone else in your house ever washed the bed net?

Y__ /N__ /Don't know__

Q57. If yes, how many times the net has been washed ____ times

PNEUMONIA

Q58. Has (name of child) been ill with cough in the last two weeks? Y__ / N__

If no, go to Q65.

Q59. Has (name of child) been ill with fast breathing in the last two weeks? Y_/N_

If no, go to Q65.

Q60. Did you seek advice or treatment for the cough/fast breathing? Y_/N__

If no, go to Q62

Q61. If yes, when? A. Same day B. Next day C. Two days D. 3 or more days

Q62. Where did you seek advice/care?

A. Health Facility B. Traditional Healer C. Drug seller D. Other (specify)___

Q63. If taken to the hospital, was (name of child) treated with any medicine before going to the H/facility? Y/N

Q64. If not taken to the health facility was (name of child) treated with any medicine? Y___/N___

CONTROL OF DIARRHEA DISEASE

Q65. Has (name of child) been ill with diarrhea in the last two weeks? Y_ / N___

Q66. When do you wash your hands with soap/ash?

Do not prompt. Record all mentioned.

when wash hands1. _____

when wash hands2. _____

when wash hands3. _____

when wash hands4. _____

when wash hands5. _____

when wash hands6. _____

HIV/AIDS

Q67. Have you ever heard of an illness called AIDS? Y___ /N ___

If no, go to Q72

Q68. What can a person do to avoid getting AIDS or the virus that causes AIDS?

Do not prompt. Record all mentioned.

STOPHIV1. _____

STOPHIV2. _____

STOPHIV3. _____

STOPHIV4. _____

STOPHIV5. _____

STOPHIV6. _____

STOPHIV7. _____

STOPHIV8. _____

STOPHIV9. _____
STOPHIV10. _____
Other (specify) _____

Q69. Can the virus that causes AIDS be transmitted from a mother to a child? Y/N
If no, go to Q69

Q70. If yes, how can the virus be transmitted from a mother to a child?

MTCTA. _____
MTCTB. _____
MTCTC. _____
MTCTD. _____
Other (specify) _____

Q71. If testing were available, would you be interested in HIV testing? Y/N

Q72. Have you ever heard of people meeting who had been tested for HIV,
regardless whether they were positive or negative? Y___/N___

Q73. The last time you had sexual intercourse did your partner use a condom?
Y___/N___

HOUSEHOLD QUESTIONS

Q74. What is the main source of drinking water for members of your household?
A. Open well B. Covered well C. Bore hole D. Pipe-borne E. River
F. Other (specify) _____

Q75. What kind of toilet facility do most members of your household use? _____

Q76. Do you share the toilet facility with other households? Y__ /N __

THANK THE MOTHER FOR THE TIME SHE GAVE TO ANSWER YOUR
QUESTIONS.

•

KPC QUESTIONNAIRE (CHITUMBUKA VERSION)

Record Number.....

CHITIPA DISTRICT- CHILD SURVIVAL PROJECT KPC, APRIL 2005

MAFUMBO AGHA TIFUMBENGE WAMAMA AWO WALI NA WANA
WAKUCHEPERA VYAKA VIWIRI

IVYO VALEMBEKA MUMALEMBA GHAKULUGHAKULU NINDONDOMEKO
YA WALEMBI, ndipo ivyo vyalembeka m'malemba ghadoko-ghadoko nimafulumbo
awo walembi wakufumba wamama.

1. ZUWA LAKUFUMBIRA.....
MULEMBI.....
NAMBALA YA NYUMBA.....
MUZI.....

MAFUMBO GHACHISANISANI

2. Kasi muli na vyaka vilinga?.....Kasi mukababika chaka
uli?.....

Sono nimufumbenenge mafumbo ghanyake ghakukhwaskana na imwe.

3. Kasi masambiro mukalekezga kalasi uli? ZINGILIZGANIZGOLO
LIMOZA
A. STD 1-5 B. STD 6-8 C. FORM 1-4 D. MAKALASI GHANYAKE E. PALIJE

4. Kasi mukukhala na wana walinga awo wandakhwaniske vilimika
vinkhonde?.....

5. Pa wana awa winu mbalinga?

PALA WANA WAKUCHEPERA VILIMIKA VINKHONDE WAJUPHA YUMOZA
LUTANI KU FUMBO 7

6. PALA MWANA WAKUCHEPERA VILIMIKA VINKHONDE WALIPO
YUMOZA PERA:

Kasi zina lake ninjani, nimwanalume panyake nimwanakazi ndipo wakababika
pawuli?

ZINA LA MWANA	MWANALUME/MWANAKAZI	DAZI LAKUBABIKIRA

LUTANI KUFUMBO NAMBALA 8

7.PALA WANA MBANANDI WAKUCHEPERA VYAKA VINKHONDE:
Mazina yawo mbanjani, mbanalume panji mbanakazi,ndipo wakababika pawuli?

MAZINA GHA WANA	WANALUME/WANAKAZI	MADAZI GHAKUBABIKILA

MAFUMBO AWO NIFUMBENGE SONO NGAKUKHWASKANA NA MWANA WINU MUDOKO CHOMENE WAKUCHEPERA VILIMIKA VIWIRI

MAFUMBO GHAKAKULIRO KA WANA NA KATEMERA

8.Kasi wana wakuchepera vilimika viwiri walipo?

A. INYA, WOSE WALIPO B. WANYAKE PALIJE

9.Kasi tingawakwezga pa sikelo?

ZINGILIZGANI ZGOLO

LIMOZA PALA ZGOLO NI YAYI LUTANI KUFUMBO 11

A. INYA B. YAYI

10. PALA WAMAMA WAZOMERA KWEZGANI MWANA PA SIKERO NA KULEMBA SIKERO KWAMBULA MAPOYINTI.....

11.Kasi(ZINA) wali na kadi yasikelo?

ZINGILIZGANI

ZGORO LIMOZA

A. WALIJE (yilikutayika, yilikutimbanizgika, yilikunyake)

LUTANU KU

FUMBO 13

B. NKHUMANYA CHARA

LUTANI KU FUMBO

13

C.WANDAWEPO NAYO

LUTANI KU FUMBO

13

D.INYA

LUTANI KU FUMBO

11b

11.(b) PALA ENYA FUMBANI “Ningayiwona?”

A .ENYA, MULEMBI WAYIWONE

B. PALIJE

12.WONANI KADI YA SIKELO YA MWANA NDIPO LEMBANI PALA WAKAKWEZGEKA PA SIKELO PA MYEZI YINAYI IYO YA JUMPHA.
ZINGIZGANI CHIMOZA

A.INYA B. YAYI

PALA KATEMERA MU KADI YA SIKELO MULIJE FUMBANI FUMBO 13a. PALA KATEMERA WALIMO LUTANI KUFUMBO 14

13.(a) Kasi muli nayo kadi panyake pepala apo pali kulembeka katemera wa (ZINA)? ZINGIZGANI ZGOLO LIMOZA

A. WALIJE(yilikusowa/yilikutimanizgika, yilikunyake) LUTANI KUFUMBO 17
B.NKHUMANYA CHARA LUTANI KUFUMBO 15
C.WANDAWEPO NAYO LUTANI KUFUMBO15
D.INYA LUTANI KUFUMBO13b

13.(b)PALA INYA ,FUMBANI “Ningayiwona?”ZINGILIZGANI ZGOLO LIMOZA

A.INYA ,MULEMBI WAYIWONA
B. PALIJE

14.NJIZGANI KATEMERA NGA NI UMO WALEMBEKERA PA KADI YA MWANA

KATEMERA	DAZI LAKUPOKERA
BCG	
POLIO 0	
POLIO 1	
POLIO 2	
POLIO 3	
DPT 1	
DPT2	
DPT3	
MEASLES	
FULLY IMMUNISED	

15.(a)WONANI MU KADI YA SIKELO. WONANISO MADAZI NA MSINKHU UWO MWANA WAKAPOKERA MANKHWALA GHA NDOPA.

15.(b)WONANISO MU KADI YA MWANA MADAZI NA MSINKHU APO VITAMIN A WAKAPERKEKA

DAZI LAKUPEREKERA VITAMINI A	MSINKHU WA MWANA

16.(a)MAKHWALA GHA NDOPA YAKAPERKEKA (ZINGILIZGANI ZGOLO LIMOZA)

A.INYA B. YAYI PALA YAYI LUTANI KUFUMBO NAMBALA 17

16.(b)YAPEREREKEKA KALINGA(ZINGILIZGANI ZGOLO LIMOZA)

A.MADAZI GHOSE CHIFUKWA CHA KULWARA

B.SABATA YILI YOSE NGA NDI UMO TILI KUPHALILIKIRA

C.MAZGOLO YANYAKE (LONGOSOLANI).....

16.(c)FUMBANI WAMAMA “Kasi (ZINA)wali kupokerapo mankhwala gha ndopa sabata yili yose?”

A. INYA B. YAYI C. NKHUMANYA CHARA

MAFUMBO GHA MAMA

17.(a)Kasi muli kupimikapo na waliyose pa nthumbo ya (ZINA)? ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

PALA YAYI LUTANI KUFUMBO

NAMBALA 23a

17.(b) PALA INYA Ninjani wakamupimani? ZINGILIZGANI MAZGOLO AWO GHAKWENERERA

A.WANTHU WAKUCHIPATALA

B.WAZAMBA

C.WANKHAZI

D.WANYAKE(ZUNULANI).....

18.Awo mwayowoya wakampimani kalinga?.....

19.(a)Muli nayo kadi ya sikelo? ZINGILIZGANI ZGOLO LIMOZA

A. PALIJE (yilikusowa/yilikutimbanizgika, yilikunyake) LUTANI KUFUMBO

NAMBALA 23a

B.NKHUMANYA YAYI .

LUTANI KUFUMBO NAMBALA 23a

C.NINDA WEPO NAYO

LUTANI LUTANI KUFUMBO

NAMBALA 25a

D.INYA

LUTANI KUFUMBO NAMBALA 19b

19.(b) PALA INYA FUMBANI “Ningayiwona?” ZINGILIZGANI ZGOLO LIMOZA

A.INYA MULEMBI WAYIWONA

B.PALIJE

PALA INYA MAFUMBO 20-24 YAKUKHWASKANA NA KADI YA MWANA YA SIKELO PANJI KATEMERA WA TTV

20.WONANI NAKULEMBA MAULENDO GHA CHIPIMO

A.MIYEZI YITATU YAKWAMBA (1,2,3)

B.MIYEZI YITATU YACHIWIRI (1,2,3)

C.MIYEZI YITATU YAWUMALIRO(1,2,3)

22.WONANI PA KADI NAKULEMBA UNANDI WA MANKHWALA GHA
NDOPA AGHO WAKAPOKERA KU SIKELO NDIPOSO NAWUMO
WAKAPOKERERA MANKHWALA GHA FANSIDA PA CHIPIMU
LEMBANI NAMBALA YA MANKHWALA GHA NDOPA AGHO
WAKAPOKERA.....

MUYEZGO WA FANSIDA

A.KAMOZA

B.KAWIRI

C.WANDAPOKEREPO

23.PALA KADI YA MAMA MULIJE KATEMERA FUMBANI “ Kasi muli na
pepala apo pali kulembeka katemera pa ulwari wa (ZINA)?”

ZINGILIZGANI ZGOLO LIMOZA

A.PALIJE (Yili kusowa /kutimbanizgika /yilikunyake) LUTANI KUFUMBO
NAMBALA 25a

B.NKHUMANYA YAYI

LUTANI KUFUMBO NAMBALA

25a

C.NINDAWEPO NAYO

LUTANI KUFUMBO NAMBALA 25a

D.INYA

LUTANI KUFUMBO NAMBALA 25b

24.WONANISO MU KADI NA KULEMBA MADAZI AGHO WAKAPOKERA
KATEMERA

KATEMERA (TTV)	DAZI LAKUPOKERA

25.(a)Pawulwali wa (ZINA)mukapokera makatemera? ZINGIZGANI ZGOLO
LIMOZA

A.INYA

B.YAYI

PALA YAYI LUTANI

KUFUMBO 27

25.(b)PALA INYA, kasi pa nthumbo ya (ZINA) mukapokera katemera
kalinga?ZINGILIZGANI ZGOLO LIMOZA

A.KAMOZA

B.KAWIRI

C.KUJUMPHA KAWIRI

D. NKHUMANYA YAYI

26.Kasi mukaphalirika kuti mukupokera katemera chifukwa cha vichi?
ZINGILIZGANI MAZGOLO GHOSE AWO WAYOWOYA

-
- A. KUVIKILIRA MWANA KUKAFUMBATA
 - B. KUVIKILIRA MWANA KUMATENDA GHANYAKE
 - C. KUVIKILIRA MAMA KUMATENDA
 - D. VIFUKWA VINYAKE
 - E. NKHAPHALILIKA YAYI

27.(a)kasi pa nthumbo ya (ZINA)mukagulapo panji kupokerapo mankhwala gha ndopa? ZINGIZGANI ZGOLO LIMOZA

- A. INYA
- B. YAYI.

C. NKHUMANYA YAYI

PALA YAYI PANJI NKHUMANYA

YAYI LUTANI KUFUMBO 28a

27.(b)PALA INYA mukamwa mazuwa ghalinga mankhwala gha ndopa? ZINGILIZGANI ZGOLO LIMOZA

- A. DAZI RILILOSE
- B. PAFUPI DAZI LIRILOSE
- C. SABATA YILIOSE
- D. PANYENGO-PANYENGO
- E. NINDAMWEPO

28(a)kasi pa nthumbo ya (ZINA)mukapokerapo panji kugula fansida? ZINGILIZGANI ZGOLO LIMOZA

- A. INYA
- B. YAYI

C. NKHUMANYA CHARA

PALA YAYI PANJI NKHUMANYA CHARA LUTANI KUFUMBO NAMBALA 29

28(b)PALA INYA ,kasi mukapokerapo kalinga fansida? ZINGILIZGANI ZGOLO LIMOZA

- A. KAMOZA
- B. KAWIRI

SONONKHUKHUMBA NIMFUMBENI VYA UMO MUKACHILIRA PANYENGO YA MWANA UYU

29(a)kasi mukachilirankhu?

- A. KUCHIPATALA
- B. KUKAYA
- C. KWA WAZAMBA
- D. PA NTHOWA
- E. MALO GHANYAKE (ZUNULANI).....

29.(b) PALA WAMAMA WAKACHILIRA KUCHIPATALA,FUMBANI “kasi mbazamba awo wakamtumizganiko?”

A.INYA B.YAYI

30.Kasi (ZINA) mukamuwikankhu wakati wababika waka?

A.MAMA

B.BAWOVWIRI

C.MUKAMUYIKA KUNYAKE

D.NKHUMANYA CHARA

31.kasi mbanjani awo wakamuvwirani pakuchira ?

ZIZGIZGANI

ZGOLO LIMOZA

A.BA KUCHIPATALA

B.WAZAMBA

C.WAVWIRI

D.WANYAKE (ZUNULANI).....

E.PALIJE

PALA WAKACHILIRA KUCHIPATALA YAYI FUMBANI FUMBO NAMBALA 32,
APO YAYI LUTANI KU FUMBO NAMBALA 33.

32.(a)Kasi mdoto wakadumulira vichi?

ZINGIZGANI ZGOLO LIMOZA

A.CHIMAYI

B.LEZALA

C.VINYAKE (ZUNULANI).....

32(b)Kasi chakudumulira mdoto mukanyamula mwekha?

ZINGIZGANI

ZGOLO LIMOZA

A.INYA

B.YAYI

33(a)Mukati mwachira kasi wakawapo uyo wakazakampimani kuwona za umoyo winu? ZINGILIZGANIZGOLO LIMOZA

A.INYA B. YAYI PALA CHARA LUTANI KUFUMBONAMBALA 35

33(b)Kasi ninjani wakamupimani pa nyengo yila?

ZINGIZGANI VYOSE IVYO

WAZUNULA

A.WAKUCHIPATALA

B.WAZAMBA

C.WAVOLONTIYA

D.WAWOVWIRI

E.WANYAKE (ZUNULANI).....

34.Kasi pakajumpha mazuwa panji masabata ghalinga kuti mupimike kakwamba mukati mwachira?

A.DAZI LENELIRO

B.SABATA YAKWAMBA

C.PAKATI PA MYEZI YIWIRI

D.PAKATI PAJUMPHA MIYEZI YIWIRI

35.Kasi mukati mwachira miyezi yiwiri yakwamba mukapokera vitamini A ngati ndi uyu?

A.INYA

B.YAYI

C.NKHUMANYA YAYI

36.(a) Kasi vimanyikwiro vyakofya vya nthumbo nivichi? LEMBANI VYOSE
IVYO VYAZUNULIKA

SUZGO.....

SUZGO.....

SUZGO.....

SUZGO.....

36.(b)Kasi mungachita vichi pala mungasanga masuzgo nga ndi agha?LEMBANI
VYOSE IVYO VYAZUNULIKA

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.....

37(a)Kasi vimanyikwiro vyakofya pa nyengo yakuchira nivichi?

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.....
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.....
.....

37(b)pala mungawa mulikukaya ndipo mwasanga masuzgo nga ndi agha kasi
mungachitachi? LEMBANI NDONDOMEKO PA IVYO WAZUNULA

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.....
.....

38.(a)Kasi vimanyikwiro vyakofya pala mama wachira nivichi? LEMBANI VYOSE
IVYO VYAZUNULIKA

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.....
.....

38.(b)Pala mungawa kukaya ndipo mwasangana na masuzgo agho kasi mungachitachi? LEMBANI NDONDOMEKO ZAKWAMBA ZINKHONDE

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.....
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KULERA

.Sono nkukhumba kumfumbani vya kulela muchikaya chinu

39.Kasi mukumanyako uko mungasanga nthowa zakulera?

A.INYA B.YAYI PALA YAYI FUMBANI
FUMBO 41

40.PALA INYA FUMBANI “Ninkhu” ZINGILIZGANI VYOSE IVYO
WAZUNULA

A.MUZAMBA WA VYAKULERA

B.KUCHIPATALA

C.NG'ANGA

D.WANYAKE WAPADERA (ZUNULANI).....

41.Kasi muli na nthumbo sono? ZINGILIZGANI ZGOLO LIMOZA

A.INYA YAYI C.NKHUMANYA YAYI

PALA INYA PANJI NKHUMANYA YAYI LUTANI KUFUMBO NAMBALA 45

42.Kasi mukukhumba kubaba mwana munyake muvyaka viwiri vikwiza?

ZINGILIZGANI ZGOLO LIMOZA

A.INYA B.YAYI C.NKHUMANYA YAYI

PALA INYA PANJI NKHUMANYA YAYI LUTANI KU FUMBO NAMBALA 45.

43.Pa nyengo yasono kasi mukugwiriska ntchito nthowa yiliyose yakulera?

ZINGILIZGANI ZGOLO LIMOZA

A.INYA B.YAYI PALA YAYI LUTANI KUFUMBO NAMBALA 45

44.PALA NI INYA FUMBANI “Kasi imwe panji wafumu winu mukugwiriska ntchito nthowa uli yakulera

ZINGILIZGANI ZGOLO LIMOZA

A.KONDOMU B.MAPILISI C.NYERETE D.KUTHIRA PASI

E.NTHOWA ZAKALE F.NTHOWA ZINYAKE

(ZUNULANI).....

KUWONKHESKA NA CHAKURYA

45.Kasi muli kuwonkheskapo (ZINA)? ZINGILIZGANI ZGOLO LIMOZA

A.INYA B.YAYI PALA YAYI LUTANI KUFUMBO NAMBALA 51

46.Kasi pakajumphha nyengo yitali uli kufumira apo (ZINA) wakawirapo kufikira pa kuwonkheska?

A.NYENGO YENEYIYO

B.PAKATI PAJUMPHA OLA LIMOZA

47.Mumadazi ghakwambilira ghatatu wait wawako (ZINA)ndipo bele lindambe kufuma mwakulutilira kasi mukamuwokheska (ZINA) bele lila likamba kufuma?

ZINGILIZGANI ZGOLO LIMOZA

A.INYA B. YAYI

49.Kasi (ZINA)wakuwonkha sono?

ZINGILIZGANI ZGOLO LIMOZA

A.INYA B. YAYI

50.Sono nkhuukumba kumfumbani za mitundu ya vyakurya na vyakumwa ivyo (ZINA)wakarya musabata yamala mpaka mayilo nawusiku

FUMBANI WAMAMA ZA VYAKURYA IVYO VILI MUSI UMU NDIPO

MUZINGIZGE IVYO WAZUNULA Kasi (ZINA)

A.WAKAWONKHA BELE?

B.WAKAMWA MAJI?

C.PANJI VYAKUMWA VINYAKE?

D.VYAKURYA VYAKUKASA

E.PALI VINYAKE? ZUNULANI.....

Sono nkhuukumba kumfumbani za mitundu ya vyakurya ivyo (ZINA)wakarya musabata yamala mpaka mayiro

51.PA CHILICHOSE PAFUPI PAFUPI KAMOZA MUSABATA YAMALA FUMBANI

Kasi musabata yamala pamoza mukamupa kalinga (ZINA)chakurya?

PALA NI 7 PANJI KUJUMPHA 7 LEMBANI 8

A. CHAKURYA CHILICHOSE CHAKUFUMIRA KU LUPOKO, MAPEMBA, VINGOMA ,MPUNGA,TIRIGU,NAVINYAKE VYANTHEURA) DAZI

1.....DAZI 2.....DAZI 3.....DAZI 4.....DAZI 5.....DAZI

6.....DAZI 7.....

B. MAJUNGU, VIYAWO,MAKAROTE, MBOHOLEZISWESI) DAZI 1.....DAZI

2.....DAZI 3.....DAZI 4.....DAZI 5.....DAZI 6.....DAZI

7.....

C. VYAKURYA VYOSE IVYO VIKUWIKIRA KUSI NGA NI MBOHOLE, NAVINYAKE VYANTHEURA IVI) DAZI 1.....DAZI 2.....DAZI

3.....DAZI 4.....DAZI 5.....DAZI 6.....DAZI 7.....

D. MPHANGWE ZABILIWIRI) DAZI 1.....DAZI 2.....DAZI

3.....DAZI 4.....DAZI 5.....DAZI 6.....DAZI 7.....

E. MANGO, VIPASO, NA MPHANGWE, NTHOCHI, MAWOLENJI, MAPEYALA, MAPUNO)DAZI 1.....DAZI 2.....DAZI 3.....DAZI 4.....DAZI 5.....DAZI 6.....DAZI 7.....

F. NYAMA, NKHUKU, SOMBA, VYAKUWULUKA NGA NDI LUPUMI, MANYENYE PANJI MASUMBI) DAZI 1.....DAZI 2.....DAZI 3.....DAZI 4.....DAZI 5.....DAZI 6.....DAZI 7.....

G. VYAKURYA VINYAKE NGA NI (TCHUNGA,SKAWA) DAZI 1.....DAZI 2.....DAZI 3.....DAZI 4.....DAZI 5.....DAZI 6.....DAZI 7.....

H. VYAKURYA VINYAKE VYAKUTHIRAKO MAFUTA PANJI SITOKO)DAZI 1.....DAZI 2.....DAZI 3.....DAZI 4.....DAZI 5.....DAZI 6.....DAZI 7.....

52.Kasi (ZINA)wakarya kalinga vyakurya vyabala -bala (vyakuyska panji kuponda)mayilo lose? PALA NI 7 PANJI KUJUMPHA LEMBANI 8.....
UMO TINGAPWERELERA MWANA KUMATENDA
GHAKUPAMBANAPAMBANA.

53Nyengo zinyake wana wakulwala ndipo wakukhumbika wowwiri. Kasi nivimanyikwiro uli ivyo vikulongora kuti mwana winu wakukhumbika kupwereleka?

KUWALONGOZGA YAYI. ZINGIZGANI VYOSE IVYO WAZUNULA

A.NKHUMANYA YAYI

B.WAKUWONEKA MAKORA YAYI/WAKUSEWERA YAYI

C.WAKURYA PANJI KUMWA CHARA.

D.WAKUFOKA PANJI WAKUTONDEKA KUWUSKIKA

E.THUPI LIKUWOTCHA CHOME

F.KUTHUTA PAFUPI-PAFUPI PANJI MWAKUSUZGIKA

G.KUBOKORA CHILICHOSE

H.CHIKOKO

I.VINYAKE (ZUNULANI).....

54.Kasi kwa sabata ziwiri zajumpha (zina)wakalwalapo?. WAZGANI MWAKUKWEZGA MATENDA GHOSE AGHO GHALI MUSI NAKUZUNGILIZGA VYOSE IVYO MAMA WAZUNULA

A.KUFUMIRA

B.KUFUMIRA KWANDOPA

C.CHIKHOSO

D.KUTHUTA MWAKUSUZGIKA

E.KUTHUTA PAFUPI-PAFUPI

F.KUWOTCHA THUPI

G.MALARIA

H.CHIKOKO

I.VINYAKE (ZUNULANI).....

J.PALIJE JUMPHANI FUMBO 58

PALA MAMA WAZGORA KUTI MWANA WANDAWOTCHEPO THUPI

JUMPHANI MAFUMBO 58-63

55.Kasi (ZINA) Wakati walwala kasi mukamupa vyakumwa pachoko
,vyakuyanawaka,panyake vinandi kujumpha mazuwa ghose? ZINGILIZGANI
ZGORO LIMOZA A. PACHOKO B.VYAKUYANA WAKA C.VINANDI
KUJUMPHA NYENGO ZOSE

56.Kasi (ZINA)wakati walwala kasi mukamupa vakurya pachoko,vakuyana waka
panji vinandi kujumpha nyengo zose? ZINGILINGANI ZGOLO LIMOZA
A.PACHOKO B.VYAKUYANA WAKA C.VINANDI KUJUMPHA NYENGO
ZOSE

KUJIVIKILIRA KU MALARIA

57.Kasi (ZINA)wakuwotcha thupi sono? ZINGILINGANI ZGOLO LIMOZA
A.INYA B.YAYI

58.Kasi (ZINA)wakati walwala sabata ziwiri zajumpha mukaluta nayo kuchipatala?
ZINGILIZGANI ZGOLO LIMOZA
A.INYA B.YAYI PALA YAYI LUTANI KUFUMBO NAMBALA 61

59.Kasi apo (ZINA)thupi likati lawotcha pakajumpha nyengo yitali uli kuti mulute
nayo ku chipatala? ZINGILIZGANI ZGOLO LIMOZA
A.DAZI LENELILO
B.MACHERO
C.PAKAJUMPHA MADAZI GHAWIRI
D.PAKAJUMPHA MADAZI GHATATU

PALA BAKALUTA NAYE KU CHIPATALA FUMBANI

60.Kasi (ZINA) mukamupa mankhwala ghalighose mundalute naye kuchipatala?
ZINGILIZGANI ZGOLO LIMOZA
A.INYA B.YAYI PALA YAYI LUTANI KUFUMBO NAMBALA 64
PALA INYA LUTANI KUFUMBO NAMBALA 62

61.Kasi (ZINA)mukamupa mankhwala ghali ghose? ZINGILIZGANI ZGOLO
LIMOZA
A.INYA B.YAYI PALA YAYI LUTANI KUFUMBO NAMBALA 66

62.Kasi nimankhwala uli agho (ZINA)wakapoka? ZINGILIZGANI
MAZGOLOGHOSE AGHO GHAZUNULIKA
A.FANSIDA B.KWININI C.GHA CHILASO D.PANADOLO/ASIPILINI
E.GHANYAKE (GHAZUNULANI).....

63.Mankhwala agho mukatora nkhu? ZINGILIZGANI IVYO WAZUNULA
A.VOLONTIYA

B.GULOSALE

C.M'BALE/M'MBWEZI

D.MANKHWALA AGHO WAKAPOKA KUCHIPATALA KALE

E.KUNYAKE (ZUNULANI).....

64.Kasi muli na usikiti m'nyumba mwinu? ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

PALA YAYI LUTANI KUFUMBO NAMBALA 70

65.Kasi ninjani wakagona mu usikiti uwo usiku wajumpha? ZINGILIZGANI

MAZGOLO GHOSE GHAKWENELERA

A.MWANA

B.MAMA

C.WANYAKE(ZUNULANI).....

66.Kasi usikiti wukabizgika mu mankhwala ghakuchimbizga nyimbona nkhunguni?

ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

C.NKHUMANYA YAYI

67.Patora nyengo yitali uli kufuma apo mukabizgira usikiti winu? ZINGILIZGANI

ZGOLO LIMOZA

A.KUCHEPERA MWEZI UMOZA

B.PAKATIKATI PA MWEZI UMOZA NA MYEZI 6

C.MYEZI 6 MPAKA MYEZI 12

D.KUJUMPHA MIYEZI 12

68.Kasi imwe panji wanyinu munyumba mwinu wali kuchapapo usikiti

uwo?ZINGILIZGANI ZGOLO LIMOZA

A.YAYI

B.INYA

C.NKHUMANYA YAYI

PALA YAYI PANJI NKHUMANYA YAYI LUTANI KUFUMBO NAMBALA 70

69.PALA NI INYA FUMBANI “Kasi yachapika kalinga kufuma apo mukawira

nayo?”

CHILASO

70.Kasi (ZINA)wali kulwalapo chikhoso sabata ziwiri izo zajumpha?

ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

PALA YAYI LUTANI KUFUMBO NAMBALA

77.

71.Kasi apo (ZINA)wakalwala chikhoso wakathutanga pafupi-pafupi kujumpha nyengo zose? ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

72.Kasi mukapenja wowwiri panji mankhwala gha chikhoso panyake kuthuta pafupi-pafupi? ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

PALA YAYI LUTANI KUFUMBO LA

NAMBALA 78

73.Pakajumpha nyengo yitali uli mukati mwamanya chikhoso nakuthuta pafupi-pafupi kwa (ZINA) kuti mukapenje mankhwala?

ZINGILIZGANI ZGOLO LIMOZA

A.DAZI LENELILO

B.NAMACHERO GHAKA

C.MADAZI GHAWIRI

D.MADAZI GHATATU NA KUJUMPHA

74.Kasi wowwiri panji mankhwala mukaghasanga nkhu? ZINGILIZGANI ZGOLO LIMOZA

A.KUCHIPATALA

B.MBALE/MBWEZI

C.NG'ANGA

D.VOLONTIYA

E.WANYAKE (ZUNULANI).....

FUMBANI FUMBO NAMBALA 75 PALA (ZINA) WAKALUTA NAYO KU CHIPATALA

75.Kasi (ZINA)mukamupapo mankhwala pambere mundalute nayo kuchipatala?

A.INYA

B.YAYI

FUMBANI FUMBO 76 PALA (ZINA) WAKALEKA KULUTA NAYE

KUCHIPATALA

76.Kasi mwana mukamupa mankhwala ghalighose? ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

PALA YAYI LUTANI KU FUMBO NAMBALA 78

77.Kasi mankhwala mukaghatrankhu? ZINGILIZGANI MAZGOLO GHOSE AGHO GHAZUNULIKA

A.KWA VOLONTIYA

B.KUGOLOSE

C.KU WABALI/WABWEZI

D.MANKHWALA AGHO WAKAPOKA KALE KUCHITIPA

E.KUNYAKE (ZINULANI).....

HIV/AIDS

78.Kasi muli kupulikapo na za matenda gha EDZI? ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

PALA YAYI LUTANI KUFUMBO NAMBALA 85

79.Kasi munthu wangachita vichi kuti wajivikilire kukachibungu ako kakwambiska matenda gha EDZI? ZINGILIZGANI VYOSE IVYO VYAZUNULIKA

A.PALIJE

B.KULEKA KUGONANA

C.KUGWIRISKA TCHITO MAKONDOMU

D.KUGONA NA MUNTHU YUMOZA PERA

E.KUCHEPESKA NAMBALA YA WANTHU WAKUGONA NAWO

F.KULEKA KUGONA NA WANTHU AWO WAKUGONANA NA WALIYOSE

G.KULEKA KUGONANA NA WANALUME/WANAKAZI PERA

H.KULEKA KUGONA NA WANTHU WAKUJIGWAZA NYELETE

ZAKUZUNGUZA BONGO

I.KULEKA KUPOKERA NDOPA

J.KULEKA KUPOKERA NYERETE

K.KULEKA KUFYOFYONTHANA

L.KUCHEPESKA KULUMIKA NA NYIMBO

M.KUPENJA MANKHWALA GHAKUJIVIKILIRA KUFUMA KWA NG'ANGA

N.KULEKA KUBWEREKANA MALEZALA

O.VINYAKE (ZUNULANI)

P.NKHUMANYA CHALA

80.Kasi kachibungu ako kakwambiska EDZI kangayambukira kufuma kwa mwana kuluta kwa mwana?ZINGILIZGANI ZGOLO LIMOZA

A.INYA

B.YAYI

C.NKHUMANYA YAYI

PALA YAYI PANJI NKHUMANYA YAYI LUTANI KUFUMBO LA NAMBALA 82

81.Kasi mama wangampira uli mwana kachibungu kakwambiska matenda gha EDZI?

A.NYENGO YA NTHUMBO

B.NYENGO YAKUPHOKWA

C.PAKONKHESKA

D.NTHOWA ZINYAKE(ZUNULANI)

82.Kasi pala pangawa mwawi mungakhumba kukapimiska kuti mumanye usange muli nako kachibungu ka EDZI?

A.INYA

B.YAYI

C.NKHUMANYA YAYI

84.Kasi muli kupulikapo na za wanthu awo wali kupimiska ndopa zawo kuti wamanya kuti wali na HIV ndipo wanthu awo wakukumana pa gulu kwambula kughanaghanira kuti kwali munthu munyake wali na HIV panji yayi?

A.INYA

B.YAYI

85.Apo mukagonana kawumaliro na mwanalume/mwanakazi,kasi mukagwiriska ntchito kondomu?

A.INYA

B.YAYI

Sono nimufumbeningiso na za panyumba pinu

86.Kasi maji ghakumwa mukutekankhu/kuneghankhu nyengo zose?

ZINGILIZGANI ZGOLO LIMOZA

A.CHISIME CHAKUZENGA

B.DILAWO

C.DAMBO

D.CHISIME CHAMBULA KUZENGA

87.Kasi panyumba pano mukugwiriska ntchito chimbuzi chamtundu uli?ZINGILIZGANI ZGOLO LIMOZA

A.CHAKUJIMA

B.CHAKUCHEPESKA FUNGO

C.CHAMAJI

D.PALIJE(KUTHONDO)

88.Kasi chimbuzi chinu mukugwiriska ntchito na wazengezgani winu?

ZINGILIZGANI ZGOLO LIMOZA

A.INYA

BYAYI

89.Kasi mukugeza nyengo wuli mumawoko na sopo panji na vyoto?

KUWALONGOZGA MAZGOLO CHALA

A.TIKUGEZA CHARA

B.PAMBELE TINDANOZGE CHAKURYA

C.PAMBELE TINDANOLYESKA WANA

DPALA TAFUMA KUCHIMBUZI

E.PALA TAFUMA KUKUBIBISKA/KUPATUSKA MWANA
F.VINYAKE (ZUNULANI).....

^{iv} Chitipa Socioeconomic Profile, 2002

^v Chitipa Socioeconomic Profile, 2002

^{vi} National AIDS Commission, 2004

Health Facility Assessment Forms

Form 1: Case Management Observation (2 months up to 5 years)

HW Category _____	District: _____	Interviewer: _____	Child
Date: __/__/__			
Sex M / F	HF Type: 1=CSI 2=CSII 3=CSIII 4=PS 5=S/enf		
Name of Facility: _____;			

Read Consent Form

Consent Obtained 1= Yes 2= No

Circle One Response

Part 1: General Information

Record

Time Consultation Began ____ / ____ / ____

1.	Did HW ask the age of the child?	1=yes; 2=no	1.a	What is the age of the child?	_____ Mo
2.	Someone weighed the child?	1=yes; 2=no			
3.	Someone measured body temperature?	1=yes; 2=no			
4.	Did the HW ask what are the child's problems? <i>{codes for main complaints}</i> 1= cough/DB; 2= diarrhea; 3= fever/malaria 4= ear problem; 5=measles; 6= others (specify)	1=yes; 2=no	4.a	what reasons did the caretaker give for bringing the child to the clinic today?	{Circle all that 1 2 4 5

Part 2: Danger Signs

5.	Did the HW ask whether the child is not able to drink or breastfeed?	1=yes; 2=no
6.	Did the HW ask whether the child vomits everything?	1=yes; 2=no
7.	Did the HW ask whether the child has had convulsions at home?	1=yes; 2=no
8.	Did HW observe whether the child is drowsy?	1=yes; 2=no

Part 3: Cough

9.	Did the HW ask whether the child has cough or difficult breathing?	1= yes; 2= no
10.	<i>If the child has cough or difficult breathing, did the HW ask for how long?</i>	1= yes; 2= no
11.	Did the HW count the breaths in 1 minute?	1= yes; 2= no
12.	Did the HW check whether the child has chest indrawing (CI)? <i>{by lifting up shirt/dress}</i>	1= yes; 2= no
13.	Did the HW listen for stridor or wheeze?	1= yes; 2= no

Part 4: Diarrhea

14.	Did the HW ask whether the child has diarrhoea?	1= yes; 2= no
15.	<i>If the child has diarrhea</i> , did the HW ask for how long?	1= yes; 2= no
16.	<i>If the child has diarrhea</i> , did the HW ask if blood in stool?	1= yes; 2= no
17.	Did the HW check whether the child is thirsty or drinking poorly by offering some fluids?	1= yes; 2= no
18.	Did the HW pinch the skin of the abdomen?	1= yes; 2= no

Part 5: Fever

19.	Did the HW ask whether the child has fever?	1= yes; 2= no
20.	If the child had fever, did the HW ask for how long the child has had fever?	1= yes; 2= no
21.	If child has fever, did the HW ask whether the child has had measles in the past three months?	1= yes; 2= no
22.	Did the HW look for stiff neck?	1= yes; 2= no
23.	Did the HW undress the child to look for generalized rash/or measles?	1= yes; 2= no

Part 6: Ear Problem

24.	Did the HW ask whether the child has an ear problem?	1= yes; 2= no
25.	<i>If there is an ear problem</i> , did the HW ask whether there is an ear pain?	1= yes; 2= no
26.	Did the HW ask whether there is ear discharge?	1= yes; 2= no
27.	<i>If there is discharge</i> , did the HW ask for how long?	1= yes; 2= no
28.	Did the HW check whether there is ear discharge?	1= yes; 2= no
29.	Did the HW look for tender swelling behind ear?	1= yes; 2= no

Part 7: Malnutrition and Anemia

30.	Did the HW undress the child to look for visible severe wasting?	1=yes; 2=no
31.	Did the HW check the palms for pallor?	1=yes; 2=no
32.	Did the HW check the feet for edema?	1=yes; 2=no
33.	Did the HW determine weight-for-age status?	1=yes; 2=no

Part 8: Immunization and Vitamin A Supplementation

34.	Did the HW ask for the child's under-five card?	1=yes; 2=no
35.	If there is <5 card, did the HW check the immunization status of the child?	1=yes; 2=no
36.	Did HW identify what vaccines the child is due for today?	1=yes; 2=no
37.	Did the HW check the vitamin A supplementation status?	1=yes; 2=no

Part 9: Feeding Assessment

38.	Did the HW ask whether the child is on breastmilk?	1=yes; 2=no
39.	<i>If child is breastfed</i> , did the HW ask how many times in 24 hours?	1=yes; 2=no
40.	Did the HW ask whether the child takes other food or fluids? (For children >6m only)	1=yes; 2=no
41.	<i>If child takes other food</i> , did the HW ask how many times per day?	1=yes; 2=no

Part 10: Referral

42.	Did the HW decide to refer the child?	1= yes; 2= no	42a.	If yes, did the health worker give any pre-referral treatments?	1= yes; 2= no
43	Did the HW refer to any materials when examining the child or counseling the caretaker?	1= yes; 2= no			

Part 11: List of Drugs and Advice Given (write name of drug)

44.	List of drugs & other advice given	1= yes 2= no
a.	Antimalarial:	1= yes 2= no
b.	Antibiotic:	1= yes 2= no
c.	diarrhoea treatment PLAN	1= yes 2= no
d.	Vitamin A	1= yes 2= no
e.	Iron	1= yes 2= no
f.	Immunizations	1= yes 2= no
g.	Feeding advice:	1= yes 2= no
h.	Other	1= yes 2= no

Part 12: Health Worker/Caretaker Interaction

45.	Did the health worker or someone else in the clinic explain how to give oral medicines at home?	1= yes 2= no 3=NA
46.	Did the health worker explain to the caretaker when to bring the child back for FOLLOW-UP?	1= yes 2= no 3=NA
47.	Did the health worker advice the caretaker when to return IMMEDIATELY?	1= yes 2= no 3=NA
48.	Did the health worker give the date for the next immunization?	1= yes 2= no 3=NA
49.	Did the health worker give the date for the next vitamin A supplementation?	1= yes 2= no 3=NA

50.	NOW record the time consultation ends: ____ : ____	50a.	Duration of consultation: ____
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Form 2
Exit Interview with Caregivers of a Sick Child

Interviewer Name: _____ Interview date: ____ \ ____ District _____ Health Facility Name: _____ Caretaker Sex: 1=Male 2=Female Health Facility Type: 1=CSI 2=CSII 3=CSIII 4=PS 5=S/enf

Read Consent Form. Consent Obtained 1=Yes 2=No

Circle One Response

Q	Information on Health Services	Response
51	Child sex	1= male 2= female
52	Child age	____ Years ____ Months
53	What is your relationship to the child?	1= mother 2= father 3= Grandparent 4= other (specify)
54	Is this the child's first visit to the health center for this illness	1=yes 2= no
55	Who made the decision to seek care at the health center?	1= mother 2=father 3=grandparent 4=CG volunteer 4=other Specify
56	Did you go to anyone else for care before you came to the health center	1=yes 2= no (If no go to Q58)
57	If yes from whom did you seek health care	1=Traditional healer 2=Pastor 3=Family member 4=TBA 5=CG volunteer 6=other (specify)
58	How long did it take for you to reach the health center	____ hours ____ minutes
59	What was the main reason for bringing the child to the clinic today?	1=Diarrhea 2=fever/malaria 3=Cough/difficulty breathing 4=Skin infection/ pus wound 5=Tonsillitis/ Sore throat

		6=ear problem 7=eye problem 8=Injury 9=other Specify_____
60	How long did you wait before the HW examined the child?	
61	Did the HW tell you what was wrong with the child?	1=yes 2= no (If no go to Q63)
62	If yes, what did she tell you? (Multiple Response Possible) a. Malaria b. Diarrhea c. Dysentery d. Cold/upper respiratory infection e. Pneumonia f. Malnutrition g. Measles h. Worms i. Other (specify)	1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no
63	Did the HW or someone in the center/facility weigh the child	1=yes 2= no
64	Did the HW tell you what to do for the child at home?	1=yes 2= no (if no go to Q66)
65	If yes, what did she/he tell you? a. Give more fluids b. Continue breastfeeding c. Continue feeding/increase feeds d. Give medicine e. Other	1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no
66	Did the health worker tell you to bring the child back if the child's condition becomes worse?	1=yes 2= no (if no go to Q68)
67	If yes, how will you know the child's condition is worse? (Do not read) a. Fever continues b. child is drowsy c. child is unable to drink d. child is unable to eat e. Diarrhea continues f. Blood in stool g. Child becomes worse h. other (specify)	1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no
68	Did the HW prescribe any medicines today	1=yes 2= no (if no go to Q70)
	If yes what were they (Do not read) a. Chloroquine b. Paracetamol	1=yes 2= no

	c. Amoxycillin d. Septrin e. ORS f. Iron g. Vitamin A h. Other (Specify)	1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no
69	Do you know how and when the child should take these medicines a. Chloroquine b. Paracetamol c. Amoxycillin d. Septrin e. ORS f. Iron g. Vitamin A h. Other	1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no 1=yes 2= no
70	Did you pay for the services you received today	1=yes 2= no (f no go to Q72)
71	If yes, how much did you pay	_____ quantos
72	Were you satisfied with the services you received?	1=yes 2= no
73	What were the reasons? (Do not Read) a. HW was polite b. HW was no polite c. Drugs were available d. Drugs were not available e. Long waiting time f. Services were free g. Services were expensive h. Other	

Thank the caregiver for her/his participation

DISCUSSION GUIDE FOR FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

Facilitator's Name:.....

District:.....

Village:.....

Date:.....

Group Composition:.....

GUIDING QUESTIONS:

1. What are **all** the health problems that U5 children and mothers face in this village?

Health Problem (Local Language)	Approximate English Term	How Common? (1 or 5)**	How Severe? (1 or 5)**

***=Degree of frequency and severity: 1=Very Low; 5=Very High*

2. What do you do to mitigate the highlighted problems?
3. What are the main reasons why U5 children and mothers die in this village?
4. How do you get basic household necessities such as salt, soap, sugar, clothes etc?

5. Access to services:

SUB-AREA	HSA	HC	HP	VHC	TH	TBA	ITN COMMITTEE	OTHER AGENCIES

6. How do you identify groups of people whom you consider needy?

ANNEX F – Methodology used in Local Rapid Assessment #1

METHODOLOGY OF THE SURVEY

The TPCSP Directors invited Partners from the Ministry of Health (MOH) Chitipa District Hospital (7), Department of Social Welfare (2), and Department of Community Services (1) to participate in the survey as enumerators, 1 partner from Department of Social Welfare participated as a supervisor.

Survey teams were trained in LQAS principles and concepts that included rationale and purposes of multi stage cluster sampling, importance of coverage, results of measuring coverage, and random sampling. After the training, survey teams went for a field pre-test where 21 questionnaires were administered. Thereafter a pre-test review was conducted which included the following issues:

PRE-TEST REVIEW

1. Community entry protocol
2. Building rapport
3. Volunteer selection
4. Household selection
5. Interview process
 - Flaming of questions
 - Language
 - Time taken
6. Wrap up of the interview

We divided the survey teams into three each consisting of 7 enumerators and 1 supervisor. The catchment area is divided into 7 zones and we followed the same supervision areas during the survey. We randomly selected 54 respondents from each of 7 supervision areas using multiple stages. The process of sampling was done in four levels as follows:

Health promoter level

Names of all health promoters from each supervision area were written on a separate piece of paper each and were put in a box and one Health Education Supervisor from a different zone diced the box. Then we asked one member from a different supervision area to blindly pick one piece of paper from the box. This process was repeated until three health promoters were selected.

Care group level

Names of all care groups under each health promoter were written on a separate piece of paper each and were put in a box and one member of the survey team from a different area diced the box. Then one member of the survey team coming from a different area was asked to blindly pick one piece of paper from the box. This was process was repeated until three care groups were selected from each selected health promoter.

Volunteer level

Names of all volunteers from each selected care group were written on a separate piece of paper each and were put in a box and one member of the survey team from a different area diced the box. Then one member of the survey team coming from a different area was asked to blindly pick one piece of paper from the box. We repeated this process until three volunteers from each selected care group were selected.

Household level

All households with children of less than two years old from each selected volunteer were written on a separate piece of paper each and were put in a box and one member of the survey team from a different area dived the box. Then one member of the survey team coming from a different area was asked to blindly pick one piece of paper from the box. This process was repeated until two households from each selected volunteer were selected. If a sampled household did not have a child less than two years of age then the enumerator would go to the next household until a child of less than two years was found.

Of the 378 structured questionnaires that we planned to use, 329 were administered leaving out 49 from 2 health promoters in Chitipa North East and 1 health promoter from Chitipa North West whose areas proved impassable due to heavy rains and flooding.

MoU, MOHP(CHITIPA DISTRICT HOSPITAL)

MEMORANDUM OF UNDERSTANDING BETWEEN MOHP- CHITIPA DISTRICT HOSPITAL AND WORLD RELIEF PARTICIPATING PARTER

This Memorandum of Understanding (MoU) concerns the Partnership between MOHP (Chitipa District Hospital) and World Relief Participating Partner for the Child Survival Programme. This document is a milestone and a barometer of our clear declaration of our(MOHP/WR) purposes to work together in a spirit of professional partnership in support and commitment to the purposes and objectives of the programme.

1.0 PURPOSES

- 1.1 This MoU agreement is made between MOHP (Chitipa District Hospital) a Malawi Government Department and World Relief a humanitarian organisation.
- 1.2 MOHP (Chitipa District Hospital) agrees to support, work in Partnership and provide some resources(human and material) which form part of this Agreement.

2.0 USE OF RESOURCES

- 2.1 The use of resources provided to this Programme are to be used so as to enhance the implementation of activities defined in the project proposal. The DHMT will therefore make available to the programme office accommodation with burglar-bars for its implementing staff at Chitipa District Hospital as well as in the peripheral sites: Kameme, Misuku and Nthalire. It will also provide qualified personnel: Clinical Officers, Nurse/Midwives, Assistant Environmental Health

Officers, Community Nurses, Health Surveillance Assistants who are frontline workers and Watchmen.

- 2.2 The DHMT will make available to the Programme essential in generic terms through government, private institutions (CHAM) and communities participating in drug in drug revolving funds physically and accessible and affordable to all households in times of need. The qualified personnel will be charged with the essential drug management which will be reviewed quarterly in district management meetings that also include health centre personnel. The DHMT will also make provision of community mosquito nets, family planning educational materials and contraceptives and needed materials(supplies).

A hospital laboratory will be made available to the Programme for its operational research.

The DHMT will safe guard(secure) the Child Survival Programme's asserts alongside the district hospital's asserts in all of its institutions.

The District Health Officer as a member of the District Assembly and Assembly's District Planning Committee, in view of the upcoming Decentralisation Process, the DHO will therefore strongly influence the link of the DHMT's powers to the District Planning Committee.

3.0 CERMONIES AND ANNOUNCEMENTS

- 3.1 The MOHP(Chitipa District Hospital) will acknowledge where appropriate, any contribution of the Participating Partner with respect to the programme in speeches, press releases, publications and other electronic media, for example, during Programme inception, mid-term and end of programme evaluation.

4.0 MONITORING AND EVALUATION

- 4.1 MOHP(Chitipa District Hospital) will admit the Child Survival

Programme staff to its existing quarterly Health Management Information System Meetings where dissemination of information on health related activities from no-governmental organisations(World Vision International, CHAM health centres) and government departments(Agriculture, District Assembly) are shared in order to improve the quality and coverage of health services in the district.

- 4.2 The DHMT will periodically conduct exit interviews in the Communities in order to determine the host's(Chitipa District Hospital) and the Participating Partner's degree of achievements in improving the quality of life of programme beneficiaries throughout the programme's life.
- 4.3 The DHMT will be accountable for the programme implementation, wherever necessary will solicit solutions to constraints that may be experienced in the process of running the programme.

5.0 ARBITRATION

- 5.1 If a need for arbitration arise between MOHP(Chitipa District Health Hospital and World Relief - Participating Partner and if , following dialogue and consultation, the conflict or misunderstanding is not solved to the satisfaction of both parties, a mediator(District Assembly) appointed by Health Headquarters and mutually agreed upon both parties, will be asked to mediate. If there is still not agreement or resolution to the satisfaction of both parties(Chitipa District Hospital/World Relief), the mediator District Assembly, shall determine the next course of action to resolve the matter in question.

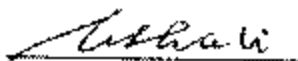
WORLD RELIEF will:

- 1.0 Process a Request For Application (RFA) through a written proposal and submit to USAID by December 2004 for approval.
- 2.0 Employ competent field staff and deploy them accordingly in Chitipa South, Chitipa central and Misuku areas.
- 3.0 Operate a project coordination office in Chitipa and have two rural sub-offices within the district.
- 4.0 Provide an efficient mechanism to enhance mobility through the use of four vehicles and 32 motor cycles. These assets remain World Relief's up until otherwise reviewed to relocate them. World Relief will at the same time provide back up support for Senior Health Surveillance Assistants where their motor cycles will be provided with fuel from time to time.
- 5.0 Provide operational office equipment to facilitate research and program implementation and monitoring.
- 6.0 Provide capacity building opportunities for DHMT, Social Welfare, District Assembly, communities and project staff to enhance resource base.
- 7.0 When and where necessary collaborate with local as well as international based support agencies to solicit more development aid to meet DHMT's needs.
- 8.0 Mobilize the Church and other stakeholders to fully participate in the implementation of Child Survival Interventions according to proposed plans as an empowerment process.
- 9.0 Make use of the lessons drawn from World Relief/Synod of Livingstonia Child Survival Program partnership in Phase one to develop new and sustainable structures in the Chitipa district. World Relief will also maintain contact with the phasing out program for purposes of enhancing learning experiences and assessing the milestones of impact.
- 10.0 Ensure that baseline survey is conducted at the start of the project to establish the level of indicators, conduct Mid-Term and End of Project Evaluations. The stakeholders will participate in all these activities.

MoU MoHP and World Relief

SIGNATURE SECTION

MoHP Chitipa District Hospital

Signature: 

Name: TOPSIE MUMBALI

Title: DISTRICT HEALTH
OFFICER

Date: 12.04.2006


Contact Address:

Chitipa District Hospital
PO Box 95
Chitipa
Malawi

Tel: 265 1 382 222/264/446

Fax 265 1 382 269:

World Relief

Signature: 

Name: VICTOR KABAGHE

Title: TPSP DIRECTOR

Date: 12/04/2006

Contact Address:

World Relief
PO Box 30717
Lilongwe 3
Malawi

Tel: 265 1 794 166

Fax: 265 1 794 155

Email: wrm@malawi.net

**CHURCH OF CENTRAL AFRICA PRESBYTERIAN
SYNOD OF LIVINGSTONIA**



HEALTH DEPARTMENT,
PO Box 1009,
MZUZU,
MALAWI
Telephone: (265) 1 334019/331 050
Fax: (265) 1 331 050
E-mail: ccaphealth@malawi.net

29 March 2006

Director for International Health
World Relief Corporation
7 East Baltimore Street
Baltimore, MD 21202

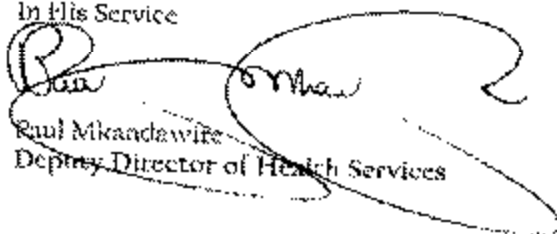
RE: WORLD RELIEF CHILD SURVIVAL PROJECT IN CHITIPA

We would like to register our support for the World Relief Child Survival Project in Chitipa district. Chitipa is one of the most underserved districts because it has rugged terrain, communication bottlenecks, poor feeder road network and diverse ethnic community. World Relief efforts in the district represent a bold step to stem maternal and child morbidity and mortality in an area that is politically remote and with limited health care options. This project brings hope to estimated 150,000 people in the district.

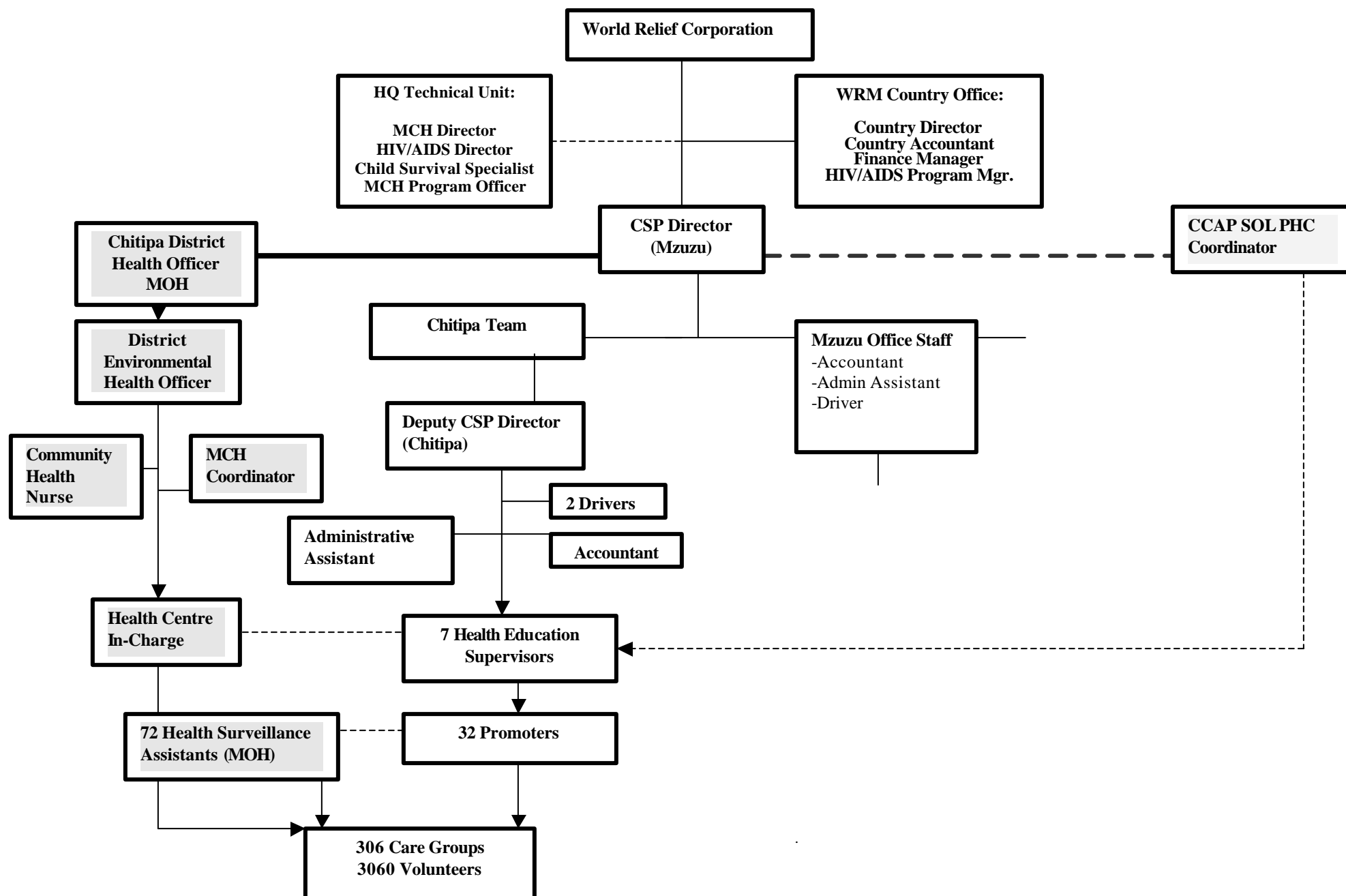
CCAP Synod of Livingstonia Health Department made a strategic decision to work with communities in the district under the Health Expansion Program. Consequently, a health center has been constructed at Musumbe due to start operation later this year and expansion of the malaria prevention activities focusing on bed net use amongst pregnant women and under-fives are underway. We therefore, strongly believe the complimentary nature of the activities of the two organizations in the district will create synergy to optimize effectiveness and impact. In addition, the community mobilization and behavioral change strategy applied by World Relief Child Survival Project has the potential to create a robust community structures for subsequent public health and broader developmental interventions.

We are looking forward to successful interventions in Chitipa

In His Service


Paul Mkwandawire
Deputy Director of Health Services

ORGANIZATIONAL CHART



Curriculum Vitae
Rachel Hower, MPH

World Relief 7 E. Baltimore St. Baltimore, MD 21202 Tel. 443-451-1900 Email: rhower@wr.org

PROFILE: Dedicated and creative public health professional with research, administrative and community experience. Skilled in:

- Written and Oral Communication
- Monitoring and Evaluation
- Program Development and Implementation
- Quantitative and Qualitative Data Analysis
- Proposal Development
- Epidemiological Analysis

EDUCATION:

Johns Hopkins Bloomberg School of Public Health, Baltimore, MD

Master of Public Health, May, 2004

Wheaton College, Wheaton, IL

Bachelor of Arts in Sociology, *cum laude*, May, 1998

Human Needs and Global Resources Certificate

PROFESSIONAL EXPERIENCE:

Maternal and Child Health Specialist

World Relief, Baltimore, MD, April 2005 – present

- Provide technical support to MCH Programs in Africa, Asia and the Caribbean.
- Develop proposals, reports and budgets for submission to multiple donors including USAID (OFDA and the Child Survival and Health Grants Program).
- Communicate World Relief's innovations and experience in child survival (e.g. Presentations at the March 2006 Care Group Workshop in Mozambique and the June 2006 USAID Child Survival & Health Mini-University)

Rapid Testing Program Coordinator/Consultant

The Women's Collective, Washington, DC, November 2004 – October 2005

- Managed all program activities for CDC directly funded HIV-antibody testing intervention
- Supervised, supported and ensured the training of a program staff of six
- Created program protocols, policies and procedures to ensure fidelity to program model and compliance with grant requirements and government regulations
- Developed and implemented quality assurance program
- Oversaw data collection for monitoring and evaluation
- Wrote all required grant reports
- Provided client-centered HIV counseling and testing

Formative Research Field Coordinator

Cysticercosis Elimination Project, Universidad Peruana Cayetano Heredia, Johns Hopkins University, Tumbes, Peru, June 2004 – October 2004

- Coordinated formative research activities for behavior change component of multi-arm study.
- Performed content-based analysis of qualitative interviews.

- Developed survey instruments and interview guides, incorporating staff and pre-test feedback.
- Provided research methods training updates and observed data collection in the field.

Research Assistant

WHO Synthesis Intervention Effectiveness Project, Johns Hopkins University, Baltimore, MD, 2004

- Selected relevant material for meta-analysis of HIV interventions in developing countries.
- Coded articles according to strict guidelines for analysis.

AIDS Clinician/Consultant

DuPage County Health Department, Wheaton, IL, 2000 - 2003

- Led prevention team for behavior change interventions with high-risk population sub-group.
- Worked with multicultural community groups to develop new prevention strategies.
- Conducted outreach and focus groups with high-risk populations.
- Designed and implemented sexual health curriculum which included HIV/STD, family planning, domestic violence, sexual assault, decision making, partner negotiation.
- Taught HIV/STD prevention programs in a variety of community and correctional settings.
- Developed proposals and reports for state government grants.
- Provided client-centered HIV/STD counseling and testing services.
- Offered case management services to HIV positive individuals.

HIV Case Manager

The Children's Place Association, Chicago, IL, 1998 - 1999

- Assisted HIV affected families in achieving stable health care and living environments.
- Facilitated application to and interaction with community resources.
- Advocated for clients in the public sector (Public Aid, DCFS, health care, etc.).

International Development Intern: Commercial Sex Industry

Samaritana Transformation Ministries, Inc., Manila, Philippines, 1997

- Conducted qualitative research study:
 "Life Histories of Women in Prostitution in Manila, Philippines."
 Presented: 1999 Central States Anthropological Society Convention
 Winner: 1998 Illinois Sociological Foundation Student Paper Competition
- Reviewed literature regarding the Commercial Sex Industry from mostly Filipino publications.
- Observed streets and bars regularly for description of local sex industry.
- Interviewed respondents and analyzed factors influencing entrance into and exit from CSI.
- Analyzed appropriateness of development organization's programs.

SPECIAL SKILLS:

Language: Proficient in speaking, reading and writing Spanish

Computer: Microsoft Office, AppleWorks, STATA

Curriculum Vitae
Melanie M. Morrow, MPH

World Relief 7 E. Baltimore St. Baltimore, MD 21202 Tel. 443-451-1900 Email: MMorrow@wr.org

EDUCATION

The Johns Hopkins University School of Hygiene and Public Health (JHSPH), Baltimore, MD
Department of International Health
MPH, *Delta Omega* Honor Society, 1998

The College of William and Mary, Williamsburg, VA
Major: Anthropology; Minor: Biology
BA, *Magna Cum Laude*, 1995

EXPERIENCE

Director of Maternal and Child Health, World Relief, Beginning October 2005

- Lead in the development and expansion of community-based maternal and child health (MCH) programs of World Relief and its partner agencies.
- Assure continued excellence of MCH programs through technical support and management.

Monitoring and Evaluation Specialist, World Relief, 5/04-9/05

- Established and assured implementation of an integrated monitoring and evaluation (M&E) system for the Mobilizing Youth for Life grant within the context of World Relief's HIV/AIDS and Maternal and Child Health programs.
- Trained staff in Haiti, Kenya, Rwanda and Mozambique in operation of said system and developed M&E technical capabilities in the regional offices.

Child Survival Specialist, World Relief, 2/00-5/04

- Provided technical support to USAID funded CS projects in Africa, Asia and Central America.
- Worked with field to produce annual reports, detailed implementation plans, surveys and proposals.

Content Development Manager, National Health Information Center, 3/99-2/00

- Managed development of government websites for the U.S. Office of the Surgeon General and the Healthy People 2010 Initiative.

Consultant, Quality Assurance Project, JHSPH, Division of Health Systems, 10/98-3/99

- Researched, wrote, and edited papers and proposals on topics including micronutrient deficiency, job aids and the role of community participation in improving the quality of health services.

Program Assistant (Temp.) JHU Center for Communication Programs, Latin America Division, 6/98-9/98

- Wrote reports on Youth Mobilization component of Nicaraguan National Reproductive Health Campaign and Bolivia's Gender Series Project, two "enter-educate" television series.

Fulbright Scholar, Ministry of Health (MOH), Bogotá, Colombia 7/95-7/96

- Evaluated canine rabies knowledge and pet care practices in urban and rural communities as formative research for MOH community health education program strategy.
- Designed survey instrument, lead field staff in conducting 1600 interviews and analyzed data.

SELECTED PRESENTATIONS, PAPERS & RESEARCH

Morrow, M. “Measuring Mobilizing Youth for Life: Overcoming Challenges to Monitoring and Evaluation of Community-Based HIV Prevention Programs that Target Youth.” Presentation at the Annual Meeting of the Global Health Council (GHC), Washington, DC, June 1, 2005.

Morrow, M. “The Care Group Model.” Guest lecture in *Case Studies in Primary Health Care*, a graduate level course at Johns Hopkins School of Public Health, Baltimore, MD, December 6, 2004.

Laughlin, M. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. Eds. K. Bradbury, P. Ernst, R Heidkamp, W Long, M Morrow, L Nghatsane, and O Wollinka. Produced by World Relief with partial support from CORE and USAID, 2004.

Morrow, M. “World Relief’s Child Survival Health Information System.” Presentation at the Child Survival Mini-University II, Johns Hopkins School of Hygiene and Public Health, June 7-11, 2004.

Perry, H, T Davis and M Morrow. “Measuring Mortality Patterns & Changes in Child Survival Programs.” Joint presentation at the CORE Spring Membership Meeting 2004: *Enhancing Maternal and Child Health Impact at the Country Level*. Baltimore, Maryland, May 2004.

Morrow, M, P Ernst, W Long, A Edward-Raj, H McDaniel. “Child Survival: Empowering Communities to Take Action.” Panel presentation at the Annual Meeting of the GHC, June 2003.

Ernst, P, W Long, M Morrow and C Taylor. “Reduction of Child Mortality : 1999-2003.Vurhonga 2 Child Survival Project, Chokwe District of Gaza Province, Mozambique.” Presentation at Final Evaluation Dissemination Meeting, Maputo, Mozambique, September 2003.

Ernst, P, M Morrow, W Long., and A Edward-Raj. “*Application of World Relief’s Vurhonga HMIS: Data for Community Action.*” Paper written for and presented at *Data for Action: Using Data to Improve Child Health*, a workshop by Child Survival Technical Support, CORE and USAID, September 9-11, 2002.

Morrow, Melanie M and Dr. Ricardo León Vega Aragon. “Canine Rabies and Human Behavior in Colombia, South America.” Original research presented at Johns Hopkins First Annual MPH Integrating Experience Symposium, Baltimore, MD, May 2-3, 1998.

RELATED SKILLS & ACTIVITIES

The CORE Group (Collaborations and Resources in Child Survival)

- Member, Board of Directors, May 2004 to present
- Member, Monitoring and Evaluation Working Group, 2000 to present

Christian Connections for International Health (CCIH)

- Member, 1998 to present

- Co-facilitated Monitoring and Evaluation Workshop for CCIH members held May 28, 2005.

Languages

- English
- Spanish

CURRICULUM VITAE

RICHARD HAPPY THINDWA
C/O MR. A.G.M. THINDWA
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PRIVATE BAG A232
LILONGWE.

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CAREER OBJECTIVE: To secure a position in an organization where I will be able to apply my leadership skills acquired from my studies and expertise gained from my exposure in the sector of social and transformational development.

PERSONAL DETAILS

NAME	:	Richard Happy Thindwa
RELIGION	:	Christian, C.C.A.P.
DATE OF BIRTH	:	February 28, 1978
MARITAL STATUS	:	Single

EDUCATIONAL QUALIFICATION

2000-2004 African Bible College
BACHELOR OF ARTS DEGREE
(Honors/Cum laude)
(Graduated Valedictorian)

INDUSTRIAL ORIENTATION/WORK EXPERIENCE

A. POST-GRADUATION:

2005 World Vision Malawi, Research Assistant/Enumerator, Transformational Development Indicators Evaluation

Duties and Responsibilities held at Wovwe Area Development Program:

- Data collection through questionnaires and Focus Group Discussion guides
- Analyzing and categorizing data using Analysis Worksheets
- Collaborating and networking with various community development stakeholders at grass roots level
- Facilitating discussion of the indicators by Focus Group participants using the discussion guides
- Taking of responsibilities as and when determined and delegated by management from time to time

2004-2005 Future Vision Ministries (Malawi), Programs Manager, Community Health, Education and Rural Development, Duties and Responsibilities:

- Ensuring that all programs under implementation were achieving goals and objectives of the organization by using the resources responsibly and effectively
- Ensuring proper general office administration including maintenance of operating policies systems and standards
- Developing job descriptions for all members of staff of the organization
- Assisting the Director with the development and implementation of participatory monitoring and evaluation (PM&E) system working with Community Based Organizations (CBOs)
- Data collection, analysis and periodic reporting on the activities done in the catchment area
- Developing reporting system as a mechanism for ensuring quality of programs and activities of the organization
- Promoting information flow among partners and stakeholders of the organization
- Ensuring proper documentation of all programs and activities of the organization
- Arranging and presiding over management meetings in the absence of the Director
- Attending and reporting on all stakeholder forums including District Executive Committee (DEC), Council for Non-Governmental Organizations in Malawi (CONGOMA)
- Assisting the Director with coordinating the Christian witness program
- Developing Project proposals for funding of the organization
- Assisting the Director with developing a Strategic Plan and other pertinent documents such as brochures
- Taking of responsibilities as and when determined and delegated by management from time to time

2004 Millennium Consulting and Business Services (MCBS), Research Assistant, Health Partners Inventory Survey

Duties and Responsibilities:

- Data collection using quantitative research methods such as questionnaires
- Identifying partners implementing activities within the health sector
- Establishing human and financial capacities of partners within the health sector
- Determining compliance of health partners to Malawi government standards on service delivery
- Periodic reporting to the Managing Director on the progress of work
- Taking of responsibilities as and when determined and delegated by management from time to time

B. PRE-GRADUATION:

2003 Chaminade Secondary School, Teacher Trainee, Education Practicum

Duties and Responsibilities:

- Teaching Social Development Studies and Bible Knowledge
- Attending all staff and stakeholder forums
- Taking of responsibilities as and when determined and delegated by management from time to time

2003 Save Orphans Ministries (Malawi), Logistics Officer, Community Food for Work Project

Duties and Responsibilities:

- Planning and facilitating daily operations of the Food for Work Project funded by Christian Reformed World Relief Committee (CRWRC)

- Mobilizing the communities in carrying out the Project activities
- Monitoring distribution of food items to beneficiaries
- Sensitizing the communities on Food security strategies
- Recruiting needy villages into the Food for Work Project
- Ensuring progress towards achievement of the Food for Work Project goals and objectives
- Periodic reporting to the Relief Manager on the progress of work
- Taking of responsibilities as and when determined and delegated by management from time to time

2001 Partners in Hope Medical Centre, Research Assistant, HIV/AIDS Attitudes and Awareness Survey

Duties and Responsibilities:

- Data collection on HIV/AIDS attitudes and awareness through questionnaires
- Taking of responsibilities as and when determined and delegated by management from time to time

LEADERSHIP RESPONSIBILITIES

2002-2004 African Bible College, Great Commission Ministry, Secretary

2003-2004 African Bible College, Wild Life Club, Secretary

2003-2004 African Bible College, Resident Dean Assistant

INTERESTS AND HOBBIES

- Reading historical non-fiction and group dynamics to understand more about how various societies are formed
- Reading magazines and newspapers to pace with what is happening around the world
- Social research work
- Listening to Gospel music

AWARDS/ACHIEVEMENTS

- Certificate of Participation in the Partners in Hope HIV/AIDS Attitudes and Awareness Survey, February 2002.
- Graduated Valedictorian, most outstanding student in terms of academic performance, for the class of 2004 at the African Bible College, Lilongwe, Malawi.

COMPUTER SKILLS

- Ms-Word, Excel, Email and Internet Services.



GOVERNMENT OF MALAWI

**INTEGRATED MANAGEMENT OF
CHILDHOOD ILLNESS
(IMCI) POLICY**

Accelerated scaling up of high impact interventions

PICTURE

Draft 04

January 2006

6.2 Component 1: Case management skills of health workers

The Government policy on case management is that:

- (1) All sick children under the age of five must be examined for general danger signs, which indicate the need for immediate referral or admission to a hospital.
- (2) Irrespective of the presenting complaint, all sick children must be routinely assessed for cough or difficult breathing, diarrhea, fever, and ear problems for children aged 2 months up to five years and, in addition, for bacterial infection (indicated by bulging fontanels, redness around umbilical area and skin pustules) for young infants aged 0 to 2 months.
- (3) All care providers whose children may fall ill are counseled on how to give treatment, when to return to health facility immediately, and when to return for follow up.
- (4) All under-5 children with severe illness or classification shall be given appropriate pre-referral treatment and referred to the next level of care.
- (5) Trained Health Surveillance Assistants shall provide treatment for uncomplicated illnesses at home.
- (6) Government of Malawi and its partners shall adopt five-day training on IMCI case management.

6.3 Component 2: Improving health systems

The Government policy on improving health systems is that:

- (1) All first level health facilities, including outreach clinics, shall have all essential and pre-referral drugs and supplies for the management of sick children at all times.
- (2) All first level health facilities shall have at least two health workers trained in IMCI case management.
- (3) All first level health facilities shall have readily available transportation and communication system for effective referral.

6.4 Component 3: Improving family and community practices

The Government policy on improving family and community practices is that:

- (1) Malawi shall promote the implementation of the minimum package of high impact interventions (see Annex 2) at household and village/community levels.
- (2) The policy shall recognize all the existing policies addressing or related to the elements in the minimum package.
- (3) Promotion of family and community practices should take advantage of existing and facilitatory community structures.

- (4) Community dialogue shall be introduced at the village level for sensitization and mobilization, ensuring that this is immediately followed by the availability of goods and services related to the package.



Government of Malawi

Health Information System: National Policy and Strategy

Ministry of Health and Population

October 2003

Excerpt of 41 page document:

3. Standard setting

Information collection costs money. Before investing in information, the utility of information that has been proposed to be collected will have to be justified and approved by CHIP. With regard to standard setting, the following procedures will be followed:

3.1. Defining Minimum Datasets

CHIP will approve minimum datasets required for planning, monitoring and evaluation in the health sector. The 110 health sector indicators will serve as the original minimum datasets. CHIP will be responsible for any amendment on this list.

3.2. Definition of Data Elements

CHIP will approve the definition of each data element included in the minimum datasets. Each data element will be defined on the following format.

- ⌚③ Name
- ⌚③ Unit
- ⌚③ Definition
- ⌚③ Discussion of purpose

Data to be collected on any element must be well defined and approved prior to commissioning the collection.

3.3. Dimension of Human Health Data Collection

Human data on minimum datasets will be collected on the following 4 dimensions.

- ⌚③ Time
- ⌚③ Place
- ⌚③ Age
- ⌚③ Sex

Data collected on these dimensions determine the occurrences of a specific cause of problem in any place, at any time, by sex, and by age.

3.4. Quality Control

Accuracy of data will have to be certified by respective committees before sending the data to the next level. This implies certification of data at health facility, district and national levels.

Routine data collected from health facilities, DHO, and MOHP and other agencies will not officially be released until the data supplier has had an opportunity to verify the accuracy of the data. Data verification reports will be generated and circulated to all concerned for their verification. Generally, 30 days will be given for submission of verified data.

3.5. Maintenance of National Standard in the Realm of Decentralisation

After decentralisation of management of health services to district assemblies each district will establish its own monitoring and evaluation system and collect data accordingly. As each district must collect data on the minimum datasets using the same Health Information System National Policy and Strategy October 2003 13 Republic of Malawi Ministry of Health and Population data definition in the entire country, revision of data collection forms and data processing software will remain under the custody of HIMTC.

3.6. Data Release Protocol

Data elements will be classified into two categories, namely, unrestricted and restricted, which will be grouped based on the following criteria:

⌚③ Unrestricted: Information on minimum datasets will easily be available to all users in aggregated form only. Identification information of an individual case does not belong to this category. Researchers willing to analyse identification information will require written permission from HIM secretariat. HIMS will issue an authorisation letter as per approved policy guidelines.

⌚③ Restricted: Data elements that require approval for release through the Data Release Protocol. The HMIPC will release list of restricted data, which will form part of this document.

3.7. IT Policy

The Ministry will develop its IT policy in consultation with DISTMS. Generally, the electronic equipment will be purchased from the same company and agreement will be made for maintenance. New purchase of computer will meet at least the following standards:

Processor type: Pentium III

Processor speed: 2.4 GHG

Hard disk capacity: 20 GB

Ram: 512

3.8. Data Dictionary

The data dictionary currently in use in DHIS will be regularly updated to cover the definition of all data elements that are included in the core indicators

Results Framework

